LETTERS TO THE EDITOR

Postictal psychosis related regional cerebral hyperperfusion

Postictal psychosis is a known complication of complex partial seizure in particular temporal lobe epilepsy. It usually runs a benign and self limiting course. A postictal phenomenon with focal cerebral hypofunction (similar to Todd’s palsy), rather than ongoing seizure activity, has been postulated. Surface EEG is either normal or showing non-specific slow waves. Hence, antipsychotic medications are prescribed instead of antiepileptic drugs. Until recently, the pathogenic mechanisms have remained unknown. In this communication, we report on two patients with postictal psychosis, during which a cerebral SPECT study showed a hyperperfusion signal over the right temporal lobe and contralateral basal ganglia. As hyperperfusion in ictal cerebral SPECT is closely linked to epileptic activities, our findings support a contrary explanation for postictal psychosis.

Prolonged video-EEG telemetry study was performed in patients who underwent presurgical evaluation for epilepsy surgery. Antiepileptic drugs were withdrawn to facilitate seizure recording. A diagnosis of temporal lobe epilepsy was based on analysis of the electroclinical events and, if applicable, postoperative outcome after anterior temporal lobectomy. Psychosis was diagnosed according to the fourth edition of the diagnostics and statistical manual of mental disorders (DSM-IV) criteria.

Patient 1 was a 34 year old Chinese woman with complex partial seizures since the age of 18. Her seizure control was suboptimal on a combination of antiepileptic drugs. Brain MRI showed a small hippocampus on the right. Interictal EEG showed bilateral temporal sharp waves and ictal recordings confirmed a right temporal epileptogenic focus. A Wada test confirmed right hippocampal memory dysfunction. Six hours after her last secondary generalised tonic-clonic seizure after video-EEG telemetry, she began to develop emotional lability, talking nonsense, motor restlessness, and auditory hallucination. A cerebral SPECT study was performed at day 4 after her last seizure. Her psychotic features persisted although she was taking antipsychotic medication (pimozide). Cerebral SPECT showed a clear hyperperfusion signal over the right lateral temporal neocortex and contralateral basal ganglion. An interictal cerebral SPECT study was repeated at 4 weeks after postictal psychosis which showed a complete resolution of hyperperfusion signal in the right temporal lobe and basal ganglia. Anterior temporal lobectomy was performed and she became seizure free after surgery.

Patient 2 was a 44 year old man with intractable complex partial seizures since the age of 30. His seizures were intractable to multiple antiepileptic drugs. Brain MRI showed left hippocampal sclerosis. Intercital cerebral SPECT showed a relative hyperfusion area over the left hemisphere. Intercital surface EEG was non-lateralising but ictal EEG disclosed a right hemispheric onset. On withdrawal of antiepileptic drugs, seven complex partial seizures with secondary generalised tonic clonic seizures were recorded within a period of 72 hours. His usual antiepileptic drugs were then restarted. Thirty hours after his last secondary generalised tonic-clonic seizure, he began to develop emotional lability, talking nonsense, restlessness, auditory hallucination, persecutory delusion, and delusion of superstition. Cerebral SPECT study, performed 2 days later while his psychotic features persisted, showed two relative hyperperfused areas over the right temporal neocortex and contralateral basal ganglion in addition to the original hypoperfused area over the left hemisphere. An antipsychotic agent (thioridazine) was
started after the cerebral SPECT. His psychotic symptoms resolved 2 weeks later with full recovery.

Cerebral SPECT performed during the interictal period (IP) and during postictal psychosis (PP) were analysed visually and areas of hyperperfusion were identified. Quantitative data at regions of interest (ROIs) were measured on coronal and axial slices containing basal ganglia (BG), mesial (MT), and lateral (LT) temporal lobe structures. Asymmetry index (ASI) was calculated as ((ROI focus - ROI contralateral)/ROI focus + ROI contralateral)×100%. We set an arbitrary change of ASI > 100% to be significant. As there were only two patients, statistical testing was not performed.

Both patients showed postictal psychosis and had a regional increase in rCBF over the right temporal neocortex and the left basal ganglia compared with their interictal study (figure). Quantitative analysis for patient 1 showed changes of ASI during IP and PP over right MT was +75% (-6.4647 to -1.6528); over the right LT was +517.8% (1.0727 to 12.5576); and over the left BG was +206.8% (-2.0737 to 2.21574). Quantitative analysis for patient 2 showed changes of ASI during PP over right MT was +38.8% (13.1407 to 12.6475); over right LT was +178.65% (10.4696 to 18.7057); and over left BG was +155.9% (-5.85556 to 3.27522).

Postictal psychosis is a distinct clinical event associated with temporal lobe epilepsy. The diagnosis of postictal psychosis requires a close temporal relation between bouts of complex partial seizures and the onset of psychosis. The psychosis usually develops after a cluster of complex partial seizures and is associated with temporal lobe structures. The course of postictal psychosis is usually benign and predictable. In our patients, the duration of psychotic disturbances lasted from 10 to 14 days, which is in keeping with the good prognosis. Antipsychotic drugs, such as haloperidol and fluphenazine are usually prescribed.

The underlying mechanism of postictal psychosis is unknown. Postictal cerebral hypofunction has been postulated as an analogue to Todd’s paralysis after seizure. However, the presence of increased rCBF during postictal psychosis, may suggest an alternative explanation as ictal SPECT has been shown to be highly sensitive and specific in demonstrating seizure foci.

To conclude, our results are contradictory to the hypothesis that the mechanism of postictal psychosis is the same as that of the underlying seizure. Further serial studies with cerebral SPECT or PET may enhance our understanding on the mechanism of postictal psychosis.

Oncofetal matrix glycoproteins in cerebral arteriovenous malformations and neighbouring vessels

Cerebral arteriovenous malformations (AVMs) are thought to be congenital lesions exhibiting features of either mature vascular walls or embryonal anastomotic plexes. It is generally assumed that changes in size are dependent on enlargement of the venous compartment, organisation in the setting of microhaemorrhages, and glosis. However, recent findings are consistent with the hypothesis of ongoing angiogenesis. Previous research from our laboratory disclosed that peculiar isoforms of fibronectin (FN) and tenascin (TN) typically occur in fetal and neoplastic tissues. These isoforms are a blend of structurally different glycoproteins that result from alternative splicing of the primary transcript and are mainly expressed in the extracellular matrix. Their expression is undetectable in normal adult tissues, with the exception of the vessels in the regenerating endometrium. To gain further insight into the pathobiology of the AVMs the present report sought to ascertain whether these lesions also express oncofetal FN and TN isoforms.

Tissue samples were obtained after neurosurgical excisions of ruptured AVMs. All 10 patients had experienced an intracerebral haemorrhage as the first clinical manifestation of their disease. There was no history before bleeding. Control specimens from two right gyri recti and one cerebellar tonsil were obtained, respectively, from operations for ruptured aneurysms of the anterior communicating artery or for Arnold Chiari disease.

Immunohistochemical evaluations were performed on 5 μm thick cryostat sections using a protocol reported previously. Owing to the limited amount of available material, only in a few cases was some fresh tissue retained to allow western blots. Distribution of FN and TN isoforms was investigated using three monoclonal antibodies (mAbs) or two Ab fragments, obtained by recombinant protein technology, respectively. These Abs, prepared in our laboratory, were found to work on fresh frozen material. According to the previous characterisations the BC-1 mAb and the TN-11 Ab fragments are specific for isoforms occurring almost exclusively in fetal tissues and in tumours, with the recognised TN isoform being typically associated with anaplastic gliomas (table).

Both AVMs were processed identically to the other specimens, but the primary antibody was substituted with a specific immunoglobulin of recombinant antibodies. The antibodies were blocked using the specific antiserum. The antigens were recombinant protein containing the epitope produced in E Coli. For the mAb BC-1 we used the recombinant protein containing the type-III repeat 7B–8–9. For the mAb IST-4 we used the recombinant protein containing the type-III repeat 2–8.

For the recombinant antibodies TN-11 and TN-12 the recombinant type-III repeat C and the recombinant fragment containing the BG were used respectively.

All 10 AVMs were found to contain large amounts of FN and TN, as shown by intense immunostaining with the use of the IST-9 / IST-4 mAbs and the TN-12 Ab fragment. The staining was localised either in the endothelium or the subendothelial layer. A positive response was found in several arterylevel vessels and in a few vessels with thinner walls for the TN-12 Ab fragment. Using the BC-1 mAb some of these vessels exhibited some staining (figure). In the control specimens (brain and cerebellum) both the FN isoform containing the ED-B sequence (ED-B+FN) and the type III repeat C TN isoform were absent, despite the widespread distribution of total FN and TN in the vascular walls.
Previous findings showed that ED-B+FN presents with conformational modifications in its central part and results from deregulation of FN pre-mRNA. The distribution of this isoform was found to be highly restricted in normal adult tissues. By contrast, ED-B+FN exhibited widespread distribution in the vasculature of fetal tissues, including brain, and of several types of malignancies. It was therefore regarded as a marker of angiogenesis.

Similarly, the type III repeat C TN isoform, recognised by the Ab fragment TN-11, was found to occur in the vascular walls of anaplastic gliomas. Northern blot analysis showed that the mRNA of this isoform was undetectable in normal tissues and some malignancies, but was present in large amounts in fetal tissues, including brain, and in glioblastomas.

Recent advances in the pathology of cerebral AVMs suggest that these lesions might not be static. Tyrosine kinase, an endothelial cell specific receptor upregulated in glioblastomas, was found to be highly expressed in both AVMs and in the vessels of cerebral tissue bordering the malformations, by contrast with the down regulation occurring in the vasculature of the normal brain. The pattern of distribution of structural proteins was consistent with the hypothesis of diffuse activation of angiogenesis, without specific relation to individual vessel types.

Moreover, use of the cell proliferation marker MiB-1 showed endothelial proliferation in arterioles, venules, and capillaries of the cerebral tissue neighbouring AVMs. The presence of angiogenic features in AVMs might result from maintenance of proliferating and remodelling potentials, or from a specific response to haemodynamic stress in vascular structures subjected to increased blood flow and pressure. Occurrence of these features also in vessels lying in areas peripheral to the nidus might be related to recruitment of the neighbouring vasculature, possibly dependent on focal ischaemia in the setting of arteriovenous shunting. However, the presence in apparently normal vasculature of molecules typically occurring in fetal tissues and malignancies indicate that cerebral AVMs may not be static lesions. Further studies are needed to ascertain whether this phenomenon results merely from haemodynamic stress or actually reflects an intrinsic growth potential. Should this second be the case, current therapeutic strategies would possibly require revision.

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Hashimoto’s encephalopathy presenting as “myxoedematous madness”

The neuropsychiatric sequelae of hypothyroidism range from lethargy and mental slowing to the florid psychotic illness referred to as “myxoedematous madness”. The last condition is characterised by frank hypothyroidism accompanied by psychosis, and may respond completely to thyroxine. More recently described is a syndrome of subacute encephalopathy, associated with high titres of thyroid autoantibodies, raised CSF protein, EEG abnormalities, and perfusion deficits in the presence of normal structural neuroimaging. In most cases, the encephalopathy occurs without any gross change in circulating concentrations of thyroid hormones, suggesting that an inflammatory process is responsible for the cerebral dysfunction. In the absence of pathological data, the evidence for a specific pathogenetic mechanism is largely circumstantial: a small vessel vasculitis and immune complex deposition have both been suggested.

Although none of the published cases of Hashimoto’s encephalopathy has described psychosis as a primary feature, it is possible that “myxoedematous madness”, a condition first described in detail by Asher in 1949 lies in a range of encephalopathic phenomena mediated by autoimmune mechanisms. The suggestion would certainly be consistent with the range of clinical presentations of other autoimmune cerebral vasculitides. As autoimmune thyroiditis is the commonest cause of thyroid failure in this country, patients with these disorders have been present in at least some of Asher’s original 14 cases. Although most had florid myxoedematous features at psychiatric presentation, this may simply reflect the rarity of diagnosing subclinical thyroid disease before rapid laboratory assays became widely available. Many features of the present case, however, favoured an endocrine rather than an inflammatory mechanism, suggesting that the condition of “myxoedematous madness”, though rare, remains a valid diagnostic entity.

A 63 year old market stallholder without medical or psychiatric history was brought to a local psychiatric hospital by police. His business had been in decline for several months, and his family had noticed uncharacteristic emotional lability. In the weeks preceding admission he had experienced delusions and hallucinations, and exhibited uncharacteristic behaviour. He had reported a vision of the crucifixion, and hearing the voice of his dead mother. He claimed that his house was occupied by the devil, drove around aimlessly in his car, and appeared constantly fearful and withdrawn. He was admitted on June 26, 2017.
became aggressive and threatened them with a saw. The general practitioner was called and suggested they accept a new psychotherapist and a severe depressive illness. Police assistance was requested because of the patient’s continuing violent behaviour.

On admission he was unwell but cooperative and apparently oriented. He denied depression, but displayed no insight into the irregularity of his behaviour. No psychotic features were seen, although during the admission he consistently rationalised all reported psychotogenic phenomena. He was agressive towards staff and made repeated attempts to abscond. General physical examination was unremarkable. Neurological examination was normal except for spoken language which was fluent and grammatical, but contained word finding pauses, circumlocutions, and occasional semantic errors (for example, “I just want to get my feet back on the table”). Formal neuropsychological testing, and a screen of laboratory tests for reversible causes of encephalopathy, were performed on admission, and results are presented below (column A). Attention is drawn to his mild naming deficit, and poor performance on the Rey figure, which was due to planning rather than visuospatial performance on the Rey figure, which was performed on admission, and results are presented below (column A). Attention is drawn to his mild naming deficit, and poor performance on the Rey figure, which was performed on admission, and results are presented below (column A).

In summary, therefore, this patient presented in clear consciousness with a first episode of acute psychosis, and evidence of subtle executive and linguistic neuropsychological disturbance, on the background of gradual behavioural and affective changes. He was profoundly hypothyroid due to an autoimmune thyroiditis. This was of note that, whereas his naming ability improved, performance on frontal executive tasks remained impaired. The appearance of the follow up SPECT differed minimally, if at all, from the first examination.

Alien hand sign in Creutzfeldt-Jakob disease

The clinical picture of Creutzfeldt-Jakob disease (CJD) includes various movement disorders such as myoclonus, parkinsonism, myoclonus, and hemiballism. We report on a patient with CJD who manifested the alien hand sign. We suggest that CJD should be included in the differential diagnosis of diseases which present with an alien hand.

Creutzfeldt-Jakob disease, one of the human prion diseases, is characterised by rapidly progressive mental and motor deterioration. Involuntary movements occur in about 90% of the patients in the course of the disease, the most common being myoclonus. Other movement disorders range from tremor to the alien hand phenomenon. We report on a patient with CJD who presented with an alien hand.

Alien hand is a rare and striking phenomenon defined as “a patient’s failure to recognise the action of one of his hands as his own”. One of the patient’s hands acts as a stranger to the body and is uncooperative. Thus, there is loss of feeling of ownership but not loss of sensation in the affected hand. Originally described in callosal tumours, the aetiology of alien hand also includes surgical callosotomy, infarction of the medial frontal cortex, occipitotemporal lobe, and thalamic infection, and corticobasal degeneration. A 70 year old, right handed Jewish man born in Argentina, living in Israel for the past 20 years, was admitted to the Neurology Department. Until a month before his admission, he was apparently healthy and helped in the accounting office of the village where he lived. His neurological illness had presented insidiously during the past month with unsteadiness of gait and frequent falls. He also manifested behavioural changes, became aggressive, and had visual hallucinations, perceiving insects and mice moving through his visual field. Often, he expressed his fear from seeing that the “ceiling was

<table>
<thead>
<tr>
<th>Laboratory (units)</th>
<th>A</th>
<th>B</th>
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<tbody>
<tr>
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<td>Normal</td>
</tr>
<tr>
<td>CSF</td>
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<td>6</td>
</tr>
<tr>
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<tr>
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<td>11</td>
</tr>
<tr>
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<td>25.5</td>
<td>24</td>
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<tr>
<td>Rey-Osterreith complex figure (recall) (30%)</td>
<td>Not tested</td>
<td>75%</td>
</tr>
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</table>
falling over him”. His wife mentioned bizarre, useless movements of his left hand which were present from the beginning of the disease.

On admission, he was awake, bradyphrenic, and partially collaborative. His conversation was disrupted by hallucinations. The affect was sad and he had partial insight for his mental dysfunction. He was disoriented for time, place, and situation. He could understand speech and was able to follow simple instructions involving two consecutive components. Naming was preserved. Prominent dysgraphia and dyscalculia were noticed. Immediate recall and short term memory were severely disturbed, whereas long term memory, especially for personal life events, was relatively spared. Abstract thinking was severely affected. Bimanual movements, such as clapping, were extremely difficult.

The cranial nerves were normal as were ocular fundi. The motor examination showed normal force. Deep reflexes were symmetric and plantar responses were flexor. The right arm had a dystonic posture. His gait was ataxic on a wide base.

At times, the left arm would spontaneously rise in front of the patient during speaking or while using his right hand. He was unaware of these movements until they were brought to his attention. When questioned about their purpose, the patient denied that they were voluntary. No grasping of either hand or foot was noticed. The patient had no cortical voluntary. No grasping of either hand or foot purpose, the patient denied that they were these movements until they were brought to

When a consequence of enormous or vascular pathology, alien hands can perform complex acts such as trying to tear clothes or undoing buttons. The description by MacGowan et al has characteristics of the callosal form (especially in patient 2). However, our case suggests that the alien hand sign in CJD may appear in a different type, performing less complex movements which resemble those reported by Riley et al in corticobasal degeneration. The authors described the alien limb as “involuntarily rising and touching the mouth and eyes” (patient 1). The patient thought that she “was powerless to stop this movement” and when directed to stop responded that “she did it”. Another patient’s left arm was at times “elevated in front of him”, while he was “unaware of this situation until his attention was called to it” (patient 10).

Another related phenomenon coined as “arm levitation” was reported in progressive supranuclear palsy. In these patients the arm involuntarily raised and performed semi-purposeful movements.

One common denominator between CJD, corticobasal degeneration, and progressive multifocal leukoencephalopathy, in which an alien hand sign has also been described, is multifocality. In corticobasal degeneration, it was proposed that more than one site is affected or that a “release” phenomenon occurs accounting for the aetiology of alien hand. In CJD, bilateral cortical damage to motor areas might be the origin of their subsequent isolation and disconnection.

We suggest that CJD should be added to the differential diagnosis of diseases presenting with an alien hand with or without myoclonus.

We are indebted to Professor Eran Zardel, Department of Physiology, University of California, Los Angeles, USA.

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Recurrent peripheral neuropathy in a girl with celiac disease

The involvement of the peripheral nervous system (PNS) in children with celiac disease is particularly rare. Furthermore, in both children and adults with celiac disease, neurological complications are chronic and progressive. We report on a 12 year old girl affected by celiac disease, who on two separate occasions presented with an acute peripheral neurological syndrome after accidental reintroduction of gluten in her diet. This patient was born uneventfully to healthy non-consanguineous parents with no family history of neurological or metabolic diseases. At the age of 6 months she was diagnosed as having celiac disease according to the European Society of Paediatric Gastroenterology and Nutrition criteria. Since then she was on a strict gluten free diet and was asymptomatic until the age of 10 years when severe diarrhea, vomiting, and abdominal pain manifested 6 days after the intake of corn flakes erroneously thought to be gluten free. No previous infections had been noticed. One week after the onset of these symptoms she experienced acute weakness and pins and needles sensation confined to her legs. At that time her parents stopped her intake of corn flakes on the suspicion that these were responsible for the symptoms. Despite this, symptoms worsened during the next 2 days, confining her to bed.

At hospital admission, she was alert and mentally stable. Results of general physical examination were unremarkable. Neurological examination disclosed symmetric, predominantly distal, weakness of the legs; knee jerks and ankle reflexes were depressed; plantar reflexes were flexor. Distal stocking glove decrease in pin prick and temperature with sparing of proprioception and light touch. Coordination tests were normal.

Laboratory investigations showed a white cell count of 9300/mm³. The results of the following investigations were within the normal limits: haemoglobin, erythrocyte sedimentation rate, serum urea, nitrogen, electrolytes, creatinine, glucose, transaminase, bilirubin, immunoglobulins (Igs), lead, iron, copper, urinalysis, urinary porphyrin, folic acid, and vitamins A, B, B₁₂, and E. Antibodies to C. jejuni, Campylobacter jejuni, and virulent C. jejuni strains, antiviral antibodies, specific and non-specific organs antibodies, IgA and IgG antigliadin antibodies (AGAs), IgA antiendomysium antibodies (EMAs), and IgA antireticulatium antibodies (ARA), assessed by enzyme-linked immunosorbant assay (ELISA) and immunofluorescence (IF) were also negative.

Lumbar puncture was not performed. Antibodies against gangliosides GM1 and GQ1b, myelin associated glycoprotein and myelin
basic protein were not tested. Nerve conduc-
tion studies were consistent with a predomi-
nately motor demyelinating peripheral neu-
ropathy (table). Her symptoms improved
spontaneously and she was discharged home
after 2 weeks. For 2 years she was asympto-
matic on a gluten free diet.
At the age of 12 she presented acutely with
severe abdominal pain and 8 days after a weekly
intake of bread meant to be gluten free. Two
weeks later, due to persisting gastrointesti-
nal symptoms, her parents excluded the bread
from her diet. After 2 further weeks, while the
abdominal pain was gradually improving, she
had a new episode of acute weakness in the
lower limbs and sensory abnormalities in-
cluding burning paraesthesiae. On neurologi-
cal examination the legs showed marked
depression in muscle power; absent deep
tendon reflexes, and a reduction in pain and
temperature; light touch, perception of posi-
tion, and vibration were preserved. Walking
was impaired and the patient was bedridden.
Otherwise the examination was normal.
A haemogram showed white cell counts of
9700/mm³. Laboratory investigations were
within normal values as in the past. IgA and
IgG AGA, IgA EMA, and IgG ARA assays
assayed by ELISA and IF were again negative.
Nerve conduction studies confirmed the presence
of a predominantly motor demyelinating neu-
ropathy (table). The parents refused consent
for tendon puncture or nerve biopsy.
Over the next 2 weeks her neurological dis-
abilities spontaneously improved until full
recovery was complete. After 4 weeks, AGA,
EMA, and ARA were still negative.
On her most recent admission, 1 year after
the onset of her first neurological symptoms,
she is still on a strict gluten free diet and has
no residual symptoms or signs.
The natural history of celiac disease is well
known and the typical celiac enteropathy is
often associated with several other disorders.
However, as celiac disease is a relatively com-
mmon and lifelong condition, it is likely that
some of these associations may occur by
chance.
This patient, who was diagnosed as having
frank celiac disease at the age of 6 months,
acquired two episodes of acute peripheral
neuropathy, at the age of 10 and 12 years,
respectively. Two major pieces of evidence
strongly support the assumption of a gluten
derived disease: (1) the episodes occurred on
both occasions when gluten was accidentally
reintroduced in the diet; and (2) the response
to a gluten free diet was reasonably rapid,
occuring within weeks.
The present case, however, differs clinically
from those with neurological involvement pre-
viously reported. In the paediatric age group,
in fact, neurological complications of celiac
disease are rarely encountered and are mostly
carried to the CNS; to the best of our
knowledge, there are only two previously
reported cases of CNS involvement in children
with celiac disease. In both cases, however,
Neuropathology (table). Her symptoms improved
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The present case, however, differs clinically
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viously reported. In the paediatric age group,
examined using a rating scale for the examination of frontal release signs (FRSS), with nine operationally defined items, each on a seven point semiquantitative scale. The nine reflexes were paratonia and palpomental, hand grasp, foot grasp, glabellar, rooting, snout, and visual/tactile sucking reflexes. Neuropsychological measures included the assessment of frontal lobe function (trailmaking tests A and B, behavioural dyscontrol scale, and the controlled word association (CAMCOG). Depression was assessed using the Hamilton rating scale for depression, 15 item geriatric depression scale, and diagnostic criteria for DSM IV major depressive disorder. Family history of depression, wish to die, and suicidal ideation within the past year were also recorded, as were blood pressure and a checklist for chronic physical illness.

Total FRSS scores and scores on FRSS subcales were compared between groups using the Mann-Whitney U test for independent samples. In the peripheral vascular disease group, a correlation matrix for total FRSS score against DSMIV depression, CAMCOG score, behavioural dyscontrol scale score, verbal fluency score (total number of words beginning with F, A, and S) and trailmaking test times was examined using the Spearman correlation coefficient, corrected for ties. Sex, age, education, and chronic physical illness.Behavioural dyscontrol scale scores, trailmaking A/B test times, and verbal fluency scores were first converted into binary variables according to whether they were at/above or below the median value for the group. CAMCOG score was divided into subjects scoring 69 or above or less than 69. Those associations with a two tailed significance of 0.1 or less were then entered into a linear regression equation using the stepwise method.

Patients with peripheral vascular disease had a higher mean score on the frontal release signs scale than controls (5.8 (SD 4.6) vs 1.7 (SD 1.3)). The Mann-Whitney U test (Mann-Whitney Z = 3.33, two tailed p<0.001), as well as on glabellar and rooting reflexes (table). Only one variable (trailmaking B test time) was found to be statistically significant between the two groups, limit the present study. However, there is some evidence that clinically relevant cerebrovascular disease may accompany peripheral vascular disease and that evident disruption of frontal/subcortical brain function may not present with hard neurological signs. As it is possible that silent brain infarction was present in patients with peripheral vascular disease, further studies incorporating brain imaging are required before there can be a clearer understanding of the relation between peripheral and central vascular pathology.

<table>
<thead>
<tr>
<th>Hand grasp</th>
<th>Foot grasp</th>
<th>Glabellar</th>
<th>Palpomental</th>
<th>Paratonia</th>
<th>Rooting</th>
<th>Snout</th>
<th>Sucking (tactile)</th>
<th>Sucking (visual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>pValue</td>
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*Higher mean score in people with peripheral vascular disease.

Small numbers of patients, which may also have obscured other significant findings between the two groups, limit the present study. However, there is some evidence that clinically relevant cerebrovascular disease may accompany peripheral vascular disease and that evident disruption of frontal/subcortical brain function may not present with hard neurological signs. As it is possible that silent brain infarction was present in patients with peripheral vascular disease, further studies incorporating brain imaging are required before there can be a clearer understanding of the relation between peripheral and central vascular pathology.

I thank Dr Robert Howard for supervision of this study and Professor Dr Paul Baskerville for allowing me to interview patients under their care. The study was carried out as part of a University of London MD thesis.

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Factual clock drawing and constructional apraxia

A 45 year old man presented with a 1 day history of headache, possible seizures, and left sided weakness. On the day of presentation the patient’s wife had twice found him, inexplicably, on the floor. After the second such episode she brought him to hospital for evaluation. Examination disclosed a complete left hemiplegia and hemianesthesia, although muscle tone was documented to be normal and the plantar responses downgoing bilaterally. Brain CT was normal and routine blood examination was unremarkable. There were no further seizure-like episodes and the patient was transferred to this hospital 10 days later, hemiplegia unchanged, for possible angiography and further investigations.

He was exsmoker with hypercholesterolaemia and peripheral vascular disease which had been treated by a left femoral angioplasty 5 years earlier. The angioplasty was complicated by the occurrence of a small thrombus thought to be related to dye injection, and phenytoin had been prescribed for a short time thereafter. There was a remote history of heavy alcohol use, but he had been abstinent for several years. His father had had a stroke at the age of 65.

Six months earlier the patient had also collapsed at home and been taken to hospital with a left hemiplegia. Brain CT at that time was normal, as were carotid Doppler studies and an echocardiogram. During that admission to hospital, several generalised seizure-like episodes were seen, some with retained consciousness, and he had again been started on phenytoin therapy. A follow up brain MRI was normal and it was concluded that the hemiplegia was non-organic in origin. He was described to have made a gradual, near complete, recovery from this first hemiplegic episode and was scheduled for an imminent return to work at the time of his relapse.

On transfer to this hospital the patient was alert, oriented, and cooperative. Although up to date on current affairs and able to describe the investigations performed at the transferring hospital, he scored only 23/30 on a mini mental state examination, with absent three word recall, impaired registration, and poor copying of a two-dimensional line drawing.

Further bedside neuropsychological testing showed other findings indicative of constructional apraxia and left hemineglect. Specifically, when asked to draw a clock with the time at 10 minutes to 2 o’clock, all the numbers, and the clockhands, were placed on the right hand side of the clock outline (figure A). Copying of three dimensional line drawings was also significantly impaired (figure B). When asked to bisect a line, the patient did so only minimally to the right of the midpoint (58% of the distance from the left side).

Cranial nerve examination suggested an incongruent and inconsistent left hemioporia to confrontation testing but was otherwise normal, including bilaterally symmetric optokinetic nystagmus. Motor examination showed paralisis of the left arm and leg, with bilaterally symmetric bulk, tone, and deep tendon reflexes. The plantar response was flexor bilaterally. Sensory examination showed decreased pinprick and absent light touch, joint position sense, and vibration sense on the entire left side. There was also impaired perception of a tuning fork’s vibration on the left side of the forehead, with a distinct demarcation in the midline. The rest of the physical examination was unremarkable.

Brain CT and MRI, CSF examination, and routine EEG were normal. Routine haematological and metabolic analyses plus erythrocyte sedimentation rate, serum lactate, prothrombin time/partial thromboplastin time, fasting serum glucose, HbA1c, serum Ig survey, and thyroid stimulating hormone were all within normal limits. A hypercoagulability profile was negative. A lipid profile showed mild hyperlipidaemia with increased low
density lipoprotein (3.92 mmol/l) and triglycerides (4.30 mmol/l) and low high density lipoprotein (0.73 mmol/l). Serum phenytoin concentration was therapeutic at 74 μmol/l. An ECG was normal.

Ophthalmological consultation and formal visual field testing demonstrated a concentrically constricted field of mild degree in the right eye and tunnel vision in the left eye.

The patient consented to overnight video-EEG monitoring and was seen on multiple occasions to move his left arm and/or leg in a normal fashion, at one point using the left arm to readjust his bed covers shortly after arousal from sleep, before glancing briefly at the video camera and completing the task with his right arm. The prolonged EEG was normal.

A formal neuropsychological assessment performed in hospital documented impaired attention, concentration, and working memory, as well as several atypical calculations and spelling errors, the second involving unusual “near miss” letter substitutions or reversals (for example, “amixey”, “executive”). The formal testing identified no consistent evidence of visuospatial deficits or constructional apraxia. The findings were interpreted as inconsistent with the patient’s history but the possibility of a factitious aetiology was considered.

An ECG was normal.

The inability to copy line drawings or to draw a clock is, from a neurologist’s perspective, typically associated with parietal lobe dysfunction, usually of the non-dominant hemisphere, especially if associated with left hemispatial neglect. To our knowledge, this is the first reported case of factitious clock drawing and constructional apraxia. Bedside mental status testing also demonstrated the more common simulated deficits of impaired attention and absent three word recall. In retrospect, the severe neglect on clock drawing was perhaps “too good to be true”, especially in the light of the near normal line bisection demonstrated on the same day. The mirror image distortion of the house was also very unusual and, furthermore, the mirror reversal itself is evidence of lack of clinical neglect. The distortion of the cube, however, could easily be misinterpreted as evidence of organic constructional impairment if seen in the absence of the other relevant clinical and laboratory information.

During follow up, the patient admitted to feeling tremendous occupation related stresses, and described how he had come to both fear and detest his job. Given the clear benefit to the patient of removal from his work environment, the relapse of his previous admission to hospital although this cannot be definitively proved.

The clinical and laboratory findings described above indicate beyond any doubt the non-organic nature of this patient’s left hemiplegia/hemianesthesia. His seizure-like episodes at presentation are presumed to have been non-epileptic in origin (as had been suspected during his previous admission to hospital) although this cannot be definitively proved.

The patient’s willingness to undergo medical investigations, including video monitoring, to support this speculation.

Anosognosia and mania associated with right thalamic haemorrhage

Both anosognosia and secondary mania are associated with right hemispheric lesions. These two non-dominant syndromes, however, are rarely described as occurring together. We present a patient with a right thalamic haemorrhage giving rise to profound denial of hemiplegia and elated mood. This case suggests mechanisms for the common production of mania and anosognosia.

A 53 year old, right handed, black man, with a history of alcohol misuse and dependence and untreated hypertension, was brought to the emergency room a few hours after developing an intense headache and left sided numbness and weakness.

On admission he was described as “belligerent,” “agitated,” and “confused.” Blood pressure was 240/160. Neurological examination disclosed left lower facial droop, decreased left corneal and gag reflexes, and left hemiparesis with dense sensory deficits. With increasing obtundation, the patient was transferred to the intensive care unit and intubated. Brain MRI showed a large, left sided, hyperacute thalamic bleed with mass effect and oedema. The patient was extubated 2 days later and 4 days after the stroke he was described as being drowsy and inattentive, but was able to answer questions
appropriately. Neurological examination showed contratantal gaze preference, supra-nuclear vertical gaze palsy, diffusely converging, left sided flaccid hemiparesis, and dense, left sided hemianesthesia. Deep tendon reflexes were absent on the left and Babinski’s reflex present on the left. In addition, visual extinction and neglect were present.

At the time of onset of right sided weakness the patient insisted that he was “fine,” and an ambulance was called over his objections. After being examined, the patient acknowledged that he had had a stroke, but, despite his hemiparesis, insisted that he was ready to go home and go back to work. His belief in his ability to walk led to near falls, and he was moved by the nurses to a room nearer to the nurses’ station for closer observation. He told the nurses that someone else’s arm was in his bed. On one occasion, holding up his left arm with his right, he told the nurse to “take it away; it keeps scratching me.” That the left arm “smelled funny” was another reason he wanted the nurses to take it away.

Four weeks after the stroke he first acknowledged that his left arm belonged to him and that he had not consciously recalled being otherwise. By this time he had a moderate hemiplegia and recognised “a little weakness,” but continued to insist that he was well and able to return to work. By the 6th week he had moved to a room nearer to the nurses’ station because he had never

experienced a stroke before. He told the nurses that he had not seen a physician in many weeks and that he had significant problems with concentration and memory. On tests of praxis he demonstrated a ten- der touch to the left side of his body. A request for disabled housing “so that I won’t be a burden to my family” was another reason he moved to a room nearer to the nurses’ station for thanks-giving. He told the nurses that he was well in the manic range. The mania resolved within an hour of making such statements the patient might insist that a week’s exercise he would be ready to return to work. His awareness of his hemiplegia fluctuated for 8 weeks after stroke before becoming fixed, but remained shallow after 12 weeks; he no longer planned to return to work and applied for social security disability insurance “because they say I’m disabled.”

The patient’s mood was remarkably cheerful and optimistic. A week after the stroke he was noted to praise extravgantly the hospital food, and the nurses found him “talkative.” When he arrived on our ward 11 days after stroke he was alert, well oriented, and mania co-occurring in a patient with a right thalamic haemorrhage. The coexistence of mania and anosognosia may be more com- mon than previously appreciated. The associa-

tion with anosognosia implies that the mechanisms implicated in the pathogenesis of secondary mania may be similar to those of anosognosia. The absence of evidence of abnormal parietal, temporal, or frontal lobe function by functional MRI in this case is intriguing.

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Belliveau J. Functional cerebral imaging by suscept-


Babinski J. Contribution à l'étude des troubles mental dans l'hémisphère organique cereb-


Bonneville F. Functional cerebral imaging by sus-


Epileptic cardiac asystole

A patient is reported on with habitual episodes of collapse and loss of consciousness associated with EEG evidence of focal epileptiform discharges. Simultaneous ECG recordings disclosed 25 seconds of cardiac ventricular asystole occurring 24 seconds after the onset of electrical seizure activity. After changes to antiepileptic medication and the insertion of a permanent cardiac pacemaker he had had no further episodes. In cases of epileptic cardiac dysrhythmia, isolated EEG or ECG recordings may prove insufficient and prolonged simultaneous EEG/ECG monitoring may be required.

Cardiac arrhythmias subsequent to epilep-
tic seizures have been recognised for more than 90 years. They provoke diagnostic confusion and may be a mechanism of sudden unexplained death in epilepsy. Whereas sinus tachycardia was noted to accompany more than 90% of epileptic seizures, isolated bradycardia was seen much
less commonly (only 1 of 74 seizures recorded). A review in 1996 of the “ictal bradycardia syndrome” showed only 15 documented cases in the literature of either bradycardia or asystole associated with seizures. Most patients had temporal lobe seizures. The longest duration of asystole previously reported is in a 17 year old man with temporal lobe epilepsy who sustained a 22 second pause in cardiac output. More typically the asystolic periods in documented cases are in the region of 5–10 seconds. Shorter duration asystole may not compromise cerebral function sufficiently to cause loss of consciousness. Implantation of a cardiac pacemaker is advocated but does not ensure that lapses of consciousness are eliminated if these are directly related to the seizure rather than to the secondary asystole. We report on a patient with epileptic cardiac asystole of 25 seconds duration demonstrated by prolonged simultaneous EEG/ECG monitoring which responded well to pacemaker insertion.

A previously well 34 year old right handed builder was referred with a 1 year history of fortnightly episodes of loss of consciousness. There was no associated warning, aura, chest pain, or palpitations and the patient was only aware of the episode once consciousness was lost. 

16 Channel ictal EEG (eight channels illustrated with ECG) showing electrographic seizure onset and subsequent bradycardia and asystole.
restored and he found himself lying on the floor. On recovery there was no confusion, drowsiness, dysphasia, or diuresis. Often, however, he sustained soft tissue injuries to his face and scalp.

Witnesses reported that the patient would, without warning, suddenly collapse to the ground where he would remain unresponsive, inaccessible, and motionless for 90 to 120 seconds. On two occasions he appeared confused and disorientated immediately before a collapse. During the period of unconsciousness he would demonstrate no involuntary movements, orofacial automatisms, or cyano- sis but he would become pale and “ashen” while staring straight ahead with a glazed look. The duration of the episode at his fourth return would return to normal and within 2 minutes he would have fully recovered. Unusually during one reported episode of unconsciousness he was seen to briefly extend the fingers of both hands.

He was admitted to his local hospital and CT, MRI, interictal EEG, and 24 hour ECG were normal. No episodes were witnessed while he was an inpatient but they were thought to be hypotensive in origin and therefore before he was started on phenytoin, with no benefit. Carbamazepine was added, again with minimal effect.

The patient was then referred to the Epilepsy Assessment Centre of The National Society for Epilepsy and National Hospital for Neurology and Neurosurgery for further investigation and management.

Cardiovascular and neurological examination was normal as were MRI and routine interictal EEG. Sixteen channel ambulatory EEG using an Oxford Instruments digital EEG receiver was performed continuously for 340 hours before an episode was captured. Interictally rare spikes were seen over the right temporal lobes, the right outer, and the left frontal and parietal lobes. He had normal results. No monoclonal or polyclonal antibodies to gangliosides GM1 and GD1b were detected. Analysis of CSF showed 1 lymphocyte/mm^3 and 25 mg/dl protein. Motor nerve conduction studies showed prolonged distal latencies in the right median (8.8 ms (normal value in our laboratory <4.6)) and ulnar (6.2 ms (normal<3.6)) nerves, and moderate decreased conduction velocities in the right median nerves (normal>45), ulnar (45 ms (normal>49), tibial (35 ms (normal>38)), and peroneal (29 ms (normal>41)) nerves. There were moderate decreases in the amplitude of compound action potentials in all the nerves tested, and an amplitude reduction of 50% was detected across the cubital tunnel of the right ulnar nerve. Minimum F wave latencies were prolonged in all the nerves tested. The latency in the right phrenic nerve was slightly

Respiratory insufficiency in a patient with hereditary neuropathy with liability to pressure palsy

Hereditary neuropathy with liability to pres- sure palsies (HNPP) is an autosomal domi- nant disorder, the molecular basis of which is a 1.5 mb deletion in chromosome 17p11.2 including the peripheral myelin protein-22 (PMP-22) gene. HNPP typically presents recurrent pressure palsies of peripheral nerves, such as the axillary, median, radial, ulnar, or peroneal nerves, at common entrap- ment sites. Respiratory muscle weakness has not been previously reported in HNPP. We describe a patient with HNPP in whom respiratory failure and proximal muscle weakness were prominent features.

The patient started to have dyspnoea on exertion at the age of 44. At the age of 47, he noticed a slowly progressive weakness of the pelvic girdle and lower limbs. At the age of 57, he experienced difficulty in going up stairs. However, he was almost independent in daily life. At the age of 60, he was admitted to Southend Red Cross Hospital with an episode due to CO2 narcosis (PCO2 117.6, PO2 64.0). Responding to mechanical ventilatory support, he completely recovered consciousness within a day. His respiratory condition in the daytime improved to that previously. However, he needed mechanical ventilation during sleep because of nocturnal hyperventilation.

The patient had no history of diabetes mellitus, pulmonary diseases, or other medical problems. There was no familial history of neurological disorder, including entrapment neuropathies. After a few months, he noted that in his teens he had experienced some episodes of right peroneal and right axillary nerve palsies which resolved themselves over a few months.

In a neurological examination, the patient's mental state and cranial nerves were normal. Evidence of muscular atrophy was slighter lordosis was found. The muscular atrophy was prominent in the shoulder girdle, intercostal muscles, paravertebral muscles, and pelvic girdle, and moderate atrophy was present in all four limbs (figure). There was moderate weakness of the shoulder and pelvic girdle and mild weakness of the distal limbs. The thorax showed poor respiratory movement, and the patient showed paradoxical movement of the abdomen in the supine position. Tendon reflexes were hypoactive in all limbs. The patient's sensations of touch and pain were mildly impaired in the four limbs.

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mally thin axonal myelin sheaths. The density of the myelin sheath and some abnor-
mation potentials were rare. A left sural nerve unit potentials of long duration, but denerva-
nemius muscles showed polyphasic motor biceps femoris, tibialis anterior, and gastroc-
ulnaris, brachioradialis, quadriceps femoris, supraspinatus, deltoid, biceps, flexor carpi ulnaris, brachioradialis, quadriceps femoris, biceps femoris, tibialis anterior, and gastroc-
nemius muscles showed polyphasic motor unit potentials of long duration, but denerva-
tion potentials were rare. A left sural nerve biopsy showed scattered tomacular thickening of the myelin sheath and some abnor-
mally thin axonal myelin sheaths. The density of myelinated fibres was reduced (5726/mm²).
A gene analysis disclosed a 53% gene dose of PMP-22 related to normal controls, using Southern blots of DNA digested with EcoRI.
Given the possibility of superimposing demyelinating neuropathy, especially chronic inflammatory demyelinating polyneuropathy, oral prednisolone (60 mg/day) was given for 1
month. However, the patient’s clinical condi-
tion did not respond to this treatment. Pulmonary dysfunction and proximal muscle weakness were almost steady during the next 3 years.
We examined the patient’s elder sister (64 years old), elder brother (62 years old), and younger sister (58 years old), although they had no neurological complaints. All of them had experienced generalised hyporeflexia or areflexia but no weakness or sensory loss, and nerve conduction studies showed moderate conduction slowing with accentuation at the common entrapment sites, suggesting demy-
elinating neuropathy.
Our patient recalled experiencing recur-
rent episodes of transit entrapment monone-
upathies, and the familial occurrence of asymptomatic entrapment neuropathy was detected by nerve conduction studies. The presence of tomacula, and genetic analysis confirmed a diagnosis of HNPP. However, the patient’s dominant clinical features—
respiratory failure and proximal muscle weakness—were atypical for HNPP. Al-
though respiratory muscle weakness has been reported in hereditary motor and sensory neuropathy (HMSN), there has been no report of respiratory insufficiency associated with HNPP to our knowledge.
The weakness of the truncal muscles, including the respiratory accessory muscle, is a possible cause of respiratory failure in our patient. On the other hand, he had experi-
enced hypventilation in the supine posture and paradoxical movement of the abdomen, which suggested diaphragmatic weakness.1 Also, chest radiography showed poor move-
ment of the diaphragm. Although the prolonga-
tion of distal latency in the phrenic nerve was mild considering the severity of respira-
tory failure, assessment of axonal loss is not possible with phrenic nerve stimulation. In
fact, phrenic nerve latency is not necessarily associated with pulmonary dysfunction in
HMSN.2 Diffuse proximal weakness in our patient is an uncommon finding as for HNPP. Mancardi et al3 reported on three patients with progres-
sive sensory-motor polyneuropathy associated with 17p11.2 deletion, and the initial symptom of one patient was proximal weakness in one arm. We propose that our patient represents a clinical phenotypic variability among HNPP. It may be necessary to pay attention to respira-
tory function in HNPP.

We thank Dr T Yamamoto from the University of Occupational and Environmental Health for the gene analysis and Mr T Nagase from Chiba University for his technical help with the sural nerve biopsy.

Spinal accessory neuropathy and internal jugular thrombosis after carotid endarterectomy

Spinal accessory neuropathy is a rare compi-
lcation of carotid endarterectomy (CEA).4 Internal jugular venous thrombosis after CEA has also been reported rarely, but is likely more common; as internal jugular
venous thrombosis is often asymptomatic, or presents with non-specific pain, it is probably unrecognized in many cases. Concurrent ipsilateral spinal accessory neuropathy and internal jugular venous thrombosis after CEA is expected to be rare, and this is underscored by the lack of published cases. Despite this apparent rarity, a common pathogenetic mechanism for postoperative spinal accessory neuropathy and internal jugular venous thrombosis may well be present, at least in some cases, which may lead to the consideration of the possibility of both when either is discovered.

We report on a patient who developed right spinal accessory neuropathy and internal jugular venous thrombosis after right CEA. A 59 year old man underwent right CEA for possibly symptomatic stenosis. Angiography had shown 90% stenosis of the right internal carotid. The operation was done under general anaesthesia. The carotid bifurcation was unusually distal, necessitating a long dissection and high retraction. No immediate postoperative complications were evident. The next day, the patient complained of mild pain at the operative site, but did not notice any weakness. The pain spread into his right shoulder within several days; at that time, he also noted difficulty raising his right arm. His symptoms worsened further a few weeks later, and the symptoms persisted. He presented for neurological evaluation 4 months after CEA. At that time, he had some induration along the incision site and a palpable cord within the right supraclavicular fossa. There was moderate atrophy of the right sternocleidomastoid and trapezius, with right shoulder drooping and minor right scapular winging. Right arm abduction produced more prominent scapular winging and was limited to 90 degrees due to pain and weakness. Electrodiagnostic studies were consistent with partial right accessory nerve neuropathy with minor denervation of the right trapezius. Cervical ultrasonography and MRI demonstrated right internal jugular venous thrombosis. The patient was treated with a shoulder support, analgesics, and low dose aspirin. There was no significant clinical change 1 year after CEA. Repeat electrodiagnostic studies were consistent with chronic right spinal accessory neuropathy, and repeat ultrasonography showed persistent right internal jugular venous thrombosis. Symptoms of spinal accessory neuropathy were first reported as a complication of CEA in 1982. 1 Since then, there have been several case reports and small series. 2 A 1996 review of reports of cranial neuropathy after CEA disclosed only one patient with spinal accessory neuropathy in over 3000 cases. 3 Although the authors did not include several other reports 4 which, taken together, may seem to suggest a somewhat higher incidence, the overall small number of reported cases in proportion to the hundreds of thousands of CEAs that have been done worldwide suggests that clinically significant spinal accessory neuropathy is a rare complication.

The presence of induration about the incision 1 site and a palpable supraclavicular cord in our patient led us to suspect venous thrombosis. Internal jugular venous thrombosis may occur within a week after neck dissection, often with recanalisation after several months. 5 The presence of induration about the incision site and a palpable supraclavicular cord in our patient led us to suspect venous thrombosis.

Although the onset of either spinal accessory neuropathy or internal jugular venous thrombosis in our patient cannot be determined precisely, it is likely that both developed at about the same time. The delayed worsening of our patient’s spinal accessory neuropathy in this case suggests postoperative scarring or inflammation. The lack of improvement after a year, as in some other cases of spinal accessory neuropathy after CEA, implies considerable axonal injury, but does not clarify the manner of injury.

**Ischaemic stroke in a sportsman who consumed MaHuang extract and creatine monohydrate for body building**

We report the first case of extensive cerebral infarct in a young sportsman consuming high doses of MaHuang extract and creatine monohydrate. This should be of serious concern to the community to possibly serious adverse effects of energy supplements.

A 33 year old man had a severe headache on awakening in the morning of 23 January 1999. He did not complain of any other symptoms. He was referred to our department on 26 January 1999. He had a Wernicke aphasia with a slight right sided face and arm weakness and a right Babinski sign. His blood pressure was 140/60 and his pulse 54 per minute. Brain CT showed signs of extensive left middle cerebral artery infarct. Cervical ultrasound duplex scanning and cerebral angiography were normal. Cerebral CSF examination and EEG were normal except for a patent foramen ovale.

The patient had no vascular risk factors, in particular no tobacco use, and he was perfectly fit until his stroke. He was a sportsman with 2 hours daily intensive training for body building. He was working as a baggage handler in an international airline company. During a recent journey to Miami, Florida, he bought tablets of “energy pills” in a shopping store to enhance his athletic performances. The first drug contained MaHuang extract (corresponding to 20 mg ephedra alkaloids), 200 mg caffeine, 100 mg L-carnitine, and 200 µg chromium per capsules. The second drug contained 6000 mg creatine monohydrate, 1000 mg taurine, 100 mg inosine, and 5 mg coenzyme Q10 per scoop. He consumed 40–60 mg ephedra alkaloids, 400–600 mg caffeine, and 6000 mg creatine monohydrate daily for about 6 weeks before his stroke.

Although a paradoxical embolism through a patent foramen ovale in this patient cannot be ruled out as he recently returned from a transatlantic air flight, there was no deep venous thrombosis and D-dimers were normal. However, ephedrine has an indirect sympathomimetic action and may act first for arteriolar vasoconstriction in addition to other catecholaminergic effects. Both ischaemic and haemorrhagic stroke associated with ephedrine use have been reported. 6 Acute myocardial infarction and acute psychosis have also been reported after taking ephedrine and other sympathomimetic drugs. 7 Ephedrine and its metabolites are natural products that are used in non-prescription medicines for multiple uses. MaHuang is one of the common ingredients in many non-prescription products that are used in non-prescription tablets in some countries.

Although no cardiocirculatory side effects have been reported with the use of creatine monohydrate, this compound, used in association with other drugs as energy supplement may have deleterious side effects. This may be particularly true when used at high doses in combination with sympathomimetic drugs as in our patient. Renal dysfunction has also been reported after oral creatine supplements. Our patient had a slight increase in creatinine concentration although...
it remained in the normal range. Whether the use of high doses of caffeine can enhance the cardiovascular effect of ephedrine remains a possibility as stroke after taking a combination of caffeine and amphetamine has been reported.\(^1\)

Drug addiction in sportsmen and sportswomen is becoming a major concern in our societies, involving both professionals and amateurs. As energy supplements, thought to enhance performance, are easily available in some countries without the need of medical prescription, everybody should be aware that these so-called “benign” drugs may have major adverse effects.

This first case report of an extensive cerebral infarct in a young sportsman consuming high doses of MaHuang extract and creatine monohydrate should alert the sport community to this possible adverse effect of energy supplements, particularly when used in multiple combination.

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Hyperkinetic movement disorders of facial and neck muscles such as blepharospasm, hemifacial spasm, facial myokimia, and cervical dystonia have rarely been associated with unilateral brainstem or posterior fossa pathologies. We report a case of unilateral cervicofacial dyskinesias due to an ipsilateral petroclival meningioma.

A 32 year old left handed woman complained about left sided facial dysaesthesia of the upper quadrant of her face for 1 year. In addition she had intermittent ipsilateral headache. A left sided facial palsy and hypogeusia developed. When progressive hearing loss and persistent ipsilateral tinnitus occurred she sought medical advice. She was referred to our department for further treatment after a large tumour in the left cerebellopontine angle had been demonstrated by MRI. On admission, the left corneal reflex was absent. There was marked hypoaesthesia of the first two divisions of the left trigeminal nerve and a mild left facial palsy. There was also hypogeusia of the left half of the tongue. Speech was slightly dysarthric. During examination dystonic and choreic movements of the left facial muscles were seen. The dystonic grimacing increased when the patient was being observed. There were also intermittent jerky dystonic head movements with turning of the head to the left, associated with slight elevation of the left shoulder. The facial movement disorder was clearly different from hemifacial spasm. There were no tonic or clonic synchronous contractions of facial muscles and no signs of involuntary coactivation. The patient barely noted the dyskinesias. Audiometry showed a hearing threshold at 30 Db on the left side and lack of stapedius reflex on the left side. Oculovestibular response to caloric stimulation was

**Petroclival meningioma as a cause of ipsilateral cervicofacial dyskinesias**

(A) Axial T2 weighted SE MR images of a 32 year old woman with left sided cervicofacial dyskinesias show a large left petroclival meningioma compressing the brainstem. (B) Coronal inversion recovery MR scans demonstrate marked displacement and distortion of the brainstem due to the petroclival meningioma. (C) Gadolinium enhanced axial T1 weighted SE MR scans 3 months postoperatively show complete removal of the tumour and normalisation of the displacement of the brain stem.
decreased on the left side. Furthermore, there was mild left dysarthrochoknesia.

Neuroigraphy of the facial nerve was normal on both sides. Needle myography of the left frontalis and orbiculai orculis did not show signs of denervation.

An MRI study showed a large gadolinium enhancing tumour within the left cerebellar ponte- pointe angle extending to the cavae Meck- eili with marked displacement of the brain- stem to the contralateral side (figure A and B). The clinical and angiography showed a discrete blush of the tumour as typically seen in menin- giomas. The tumour was totally removed by a combined transpetrosal supratentorial and infratentorial presigmoidal approach. The postoperative course was uneventful and there were no new deficits. The facial palsy improved slightly as well as the trigeminal hpyoesthesia. Audiometry remained un- changed. Postoperative imaging showed no residual tumour and the displacement of the brain stem within the posterior fossa had resolved (figure C). Marked improvement of the left sided craniofacial dyskinseias oc- curred during the next weeks.

The postoperative improvement of the dys- tonic and choreic grimacing and the cerebral dystonia indicates a causal association between the petroclival meningioma and the segmental hyperkinetic movement disorders. Such a rela- tionship is supported also by the absence of a fam- ily history of movement disorders and the absence of previous exposure to neuroleptic medication. Hyperkinetic movement disorders due to tumours of the brainstem or of the pos- terior fossa have been reported only rarely. Asymmetric blepharospasm was recently found in a patient with an ipsilateral mesen- cephalic cyst.7 Hemifacial spasm was seen in patients with dystonic neumrinomas, multiple myelomas, and epidermoid tumours of the cereb- lopontine angle.1 Acoustic neuromas and anaplastic pontocerebellar glioma can be asso- ciated with facial myokymia and spastic parietic facial contracture.1 Also, cervical dystonia due to tumours of the cerebelpontine angle have been reported recently1.

The pathophysiological mechanisms re- sponsible for dystonic movement disorders caused by structural or functional lesions of the brainstem are not fully understood. The possibility of denervation supersensitivity of cranial nerve nuclei has been proposed previ- ously. Alternatively, enhanced excitability of brainstem interneurons has been suggested. This pathophysiological mechanism is sup- ported by the findings of blink reflex studies in patients with blepharospasm, spasmodic dysphonia, and cervical dystonia. Tolosa et al found significantly less inhibition of the test stimulus polysynaptic late response and marked enhancement of the recovery curve of the late response under such conditions com- pared with the response in healthy subjects.

Our case provides further evidence that functional impairment by compression and distortion of the brain stem may cause hyper- kinetic cervicofacial movement disorders. It is supported also by the knowledge that such movement disorders are accessible to surgical treatment of the underlying pathology. Therefore, pa- tients with cranial or cervical dystonia or choreic dyskinseias should undergo MR imag- ing to rule out a surgically treatable cause.

Acute multifocal cerebral white matter lesions during transfer factor therapy

Transfer factor is an active substance of unknown structure present in dialysable leuko- cyte extract which is assumed to transfer cell mediated immunity in an antigen specific fashion.3 The mechanisms of action of trans- fer factor are still far from clear; in vitro dialy- lable leukocyte extract increases macro- phage activation and interleukin (IL) 1 production and enhances leukocyte chemo- taxis and natural killer function. Transfer fac- tor has been reported to stimulate the cell mediated antigen specific response in patients with various infections1; therefore, treatment with transfer factor has been suggested in patients with selective deficits in cell medi- ated immunity such as in some refractory neu- neoplasms and chronic infections. Moreover, it has been used in the treatment of uveitis.1 Administration of dialysable leukocyte ex- tract has seemed to be free of hypersensitivity, long lasting side effects, or complications, except for transitory hyperpyrexia.3

We report on a patient in whom multiple cerebral white matter lesions developed after taking dialysable leukocyte extract orally for uveitis. A 28 year old man was admitted to hospital because of headache, mental confu- sion, and right hemiparesis. He had had recurrent bilateral uveitis from the age of 12 to 14 with relapse of both eyes. In January 1995 retinal vasculitis was diagnosed at fundoscopy and in July 1995 he started oral transfer factor as dialysable leukocyte extract twice a week. He complained of gen- eralised weakness after the second dose and the referring symptoms developed after the third dose.

Neurological examination on admission showed mental confusion and severe right spastic hemiparesis with Babinski’s sign. No fever or meningismus were present.

Laboratory examinations on admission showed a slight increase in total serum protein (8.4 g/l, normal 6.0–8.0 g/l, although the serum protein fraction was normal), antistreptolysin tities (355 UI/ml, normal <200 UI/ml), and anticardiolipin IgG (30 UI/ml, normal< 12 UI/ml). Negative results were obtained for VDRL screening and serum immunoglobulins, venereal disease laboratory test, erythrocyte sedimentation rate, fibrinogenemia, C reactive protein, rheumatoid factor, Waaler-Rose, protein electrophoresis, and antibodies to DNA, antinuclear antibodies, anti-ENA, anti-SS-A, anti-SS-B, anti-smooth muscle, and antineutrophil cytoplasmic anti- bodies, lupus anticoagulant, cryoglobulins, immune complexes, complement fractions, and neoplastic markers.

Seralogical investigations showed IgG but not IgM against cytomegalovirus (CMV), Herpes simplex, Varicella zoster, Epstein-Barr virus, and Toxoplasma gondii; the Paul Bun- nel reaction, anti-HIV, and the markers of hepatitis virus B and C infection were negative.

Cell, protein, and glucose concentrations in CSF were normal. No oligoclonal bands or antibody against CMV, Herpes simplex, Varicella zoster, Epstein-Barr virus, Coxackie, Adenovirus, Enterovirus or Borrelia burgdorferi were present. Polymerase chain reaction search for Herpes simplex 1 and 2, Varicella zoster, CMV, Epstein- Barr virus, and JC virus in the CSF was negative.

Brain MRI showed several extensive asym- metric lesions in the subcortical and periven- tricular cerebral white matter, some of which exerted a mass effect on the nearby CSF spaces. All lesions exhibited thick ring-like enhancement after intravenous contrast ad- ministration (figure). The brain stem, cere- bellum, and cervical spinal cord were spared.

The patient had a progressive spontaneous remission of symptoms and signs. The neurological examination 20 days after onset showed slightly increased deep tendon reflexes on the right side and was normal 40 days later; all laboratory analyses were normal except for antistreptolysin tities (265 UI/ml). Two MR scans at 1 and 4 months after onset showed progressive reduction of the extension of cerebral white matter lesions, which did not show contrast enhancement. A final MR scan 20 months after onset showed further regression of lesions without contrast enhancement but a new large lesion in the left occipital white matter, which showed moder- ate contrast enhancement. At present, after 5 years, the patient is in a good state of health and neurological examination and laboratory tests are normal.

The close temporal relation between as- sumption of dialysable leukocyte extract therapy and appearance of cerebral white matter lesions in our patient supports the possibility that the association of the two events might not be causal. Despite the absence of biopsy, we reasonably excluded...
the diagnosis of vasculitis or neuro-Bechet's disease although in the absence of biopsy. In fact, the clinical, laboratory, and MRI findings were not typical and a low titre of anticoagulant antibodies is found in 2% of healthy subjects.

The occurrence at different time of focal cerebral white matter lesions highly supports the diagnosis of multiple sclerosis, but some clinical and laboratory findings in the our patient are not typical for this condition. Mental confusion is not common at the onset of multiple sclerosis whereas it is often found in acute disseminated encephalitis. In addition, CSF without oligoclonal banding argues against a diagnosis of multiple sclerosis, whereas it is commonly found in acute disseminated encephalitis. On the other hand the possibility that acute disseminated encephalitis may recur has been accepted and on the basis of the patient's clinical picture and CSF, we favoured such a diagnosis.

The pathogenetic mechanisms underlying the triggering, development, and duration of multiple sclerosis and acute disseminated encephalitis are still far from clear despite the progress made in unravelling them. Some findings suggest that acute disseminated encephalitis and multiple sclerosis lie at the two poles of an autoimmune range, in which autoreactive reactivity is only temporary and direct against a single antigen in acute disseminated encephalitis and multiple antigens in multiple sclerosis.

Although the hypothesis that dialysable leucocyte extract had triggered an autoimmune disorder in our patient cannot be proved, our finding is in line with the report of multiple cerebral lesions after therapy with IL-2 in patients with malignancies or HIV infections.

On the other hand, the fact that acute disseminated encephalitis is often correlated with the administration of foreign proteins, such as during vaccinations or viral infections led us to postulate in this patient a cell mediated immunological mechanism. Therefore, an immunological cross reaction between viral antigens (or other foreign material contained in vaccines) and various parts of the nervous system resulting in acute disseminated encephalitis might have occurred. As already noted, dialysable leucocyte extract contains a multitude of immunostimulating or potentially activating substances so it is impossible to pinpoint which one could have been responsible for the demyelinating effect seen in our patient. This notwithstanding, our finding indicates that neurological surveillance is worthy in patients assuming dialysable leucocyte extract therapy.

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Fahr's disease and Asperger's syndrome in a patient with primary hypoparathyroidism

Abnormal calcium phosphate metabolism has not previously been associated with Asperger's syndrome, a form of pervasive developmental disorder. Nor have symmetric calcifications of the basal ganglia, dentate nuclei and cortex, or Fahr's disease—whether idiopathic or associated with hypoparathyroidism—previously been associated with this handicap. We present the case of a 24 year old man with Asperger's syndrome, primary hypoparathyroidism, and multifocal brain calcifications.

According to medical history, the patient's mother had received weekly injections of Depoprovera during pregnancy. A single child born after a normal term delivery, he underwent surgery for an inguinal hernia at 3 weeks. Developmental milestones were only moderately delayed. At 9 months he rolled instead of crawling. He walked at 15 months, spoke at 2 years with poor articulation, and still speaks in short, unelaborated sentences. His social and language development lagged in grade school and he occasionally got into fights. In late adolescence, antisocial behaviour took the form of shoplifting and repeated long distance calls to pornographic hot lines. As an adult, his social adaptation remains poor: he currently lives with his mother and works irregularly as a dishwasher in a restaurant. He is indifferent, isolated, and resists novelty. He enjoys repetitive and solitary activities such as slot machine games and playing the piano.

Neurological examination showed bilateral hyperreflexia, mild imprecision of fine finger movements, dysgraphaesthesia on sensory testing, and a manneristic gripping handshake. There were no extrapyramidal
symptoms. His IQ score was in the low range (WISC-C=85 at the age of 13; Barbeau-Pinard=82 at the age of 17). He also presented an impairment on the Tower of London test, which measures executive function, and in a task assessing the understanding of others’ intentions. These two findings are reliably present in pervasive developmental disorders, in this IQ range. In addition, his performance on the Tower of Toronto test disclosed impaired performance in procedural learning. Psychiatric assessment showed scores above the cut off for autism according to the autism diagnostic interview (ADI), a standardised interview that requires specific training and those administering it to have a 0.90 reliability with other researchers. The subject was positive for the diagnosis of autism, being above cut off values in the three relevant areas of communication, social interactions, restricted interests, and repetitive behaviours. Nevertheless, he did not present delay in language acquisition or morphological atypicalities in language development, which corresponds to DSM-IV criteria for Asperger’s syndrome.

Brain CT showed dense calcium deposits in the basal ganglia, thalamus, cerebellar dentate nucleus, and orbitofrontal cortex, consistent with Fahr’s disease (figure). Serum calcium showed an increased activity in the basal ganglia relative to the cerebral cortex. A fine banded karyotype was normal. Serum calcium was 1.55 mM (normal 2.15–2.55 mM), phosphate 1.69 mM (normal 0.70–1.65 mM), sodium calcium was 0.80 mM at pH 7.4 (normal 1.19–1.34 mM); urinary calcium was 0.8 mM (normal 2.5–6.3 mM). Serum parathyroid hormone was below 0.6 (normal 1.0–6.55 µM/l); and a nuclear scan of the parathyroid glands showed an absence (normal). Calcium metabolism or abnormal macroscopic brain morphology. Abnormal cell counts and morphology in the cerebellar hemispheres have also been reported, but the relation of these findings to autism is controversial. Fah’s disease consists of symmetric calcifications, located mainly in the basal forebrain and cerebellum, which are of various etiologies. Cognitive and behavioural abnormalities may be present when calcifications occur early in development. A fortuitous association between pervasive developmental disorder and hypoparathyriodism, given the paucity of published cases, is plausible in the presented patient. Nevertheless, our case suggests that abnormal phospho-calcium metabolism could produce an autistic syndrome when brain calcifications cause specific neuropsychological deficits, due to their localisation. For example, errors of social judgement may be related to calcifications of the orbitofrontal cortex, whereas dysfunction of frontal-basal ganglia circuits may contribute to repetitive and ritualistic activities. Additionally, developmental lesions of the basal ganglia and cerebellum may contribute to the abnormalities of sensory attention, procedural learning, and motor intention in this patient.

The finding that the clinical picture of autism can be found in a wide range of medical conditions giving rise to organic brain dysfunction is not new, but the relation between these conditions and autism are often considered meaningless. By contrast, this case, similarly to some others suggests that dysfunction in key brain circuits may result in behavioural and cognitive abnormalities curable or indistinguishable from idiopathic pervasive developmental disorder. This case also suggests that careful biological assessment of this group of patients may disclose focal brain lesions associated with identifiable cognitive deficits. Could these clinical coincidences be instructive for a neurodevelopmental model of autism?

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3 Minshew NV, Sweeney JA, Bauman ML. Neurological abnormalities of the parathyroid glands showed an absence of activity. With a combination of vitamin D3-calcium supplementation and cognitive-behavioural therapy, serum calcium, and phosphate concentrations normalised and his behavior improved marginally.

Asperger’s syndrome is a subtype of pervasive developmental disorder of unknown aetiology. Evidence for involvement of specific brain regions in pervasive developmental disorder are scarce and inconclusive.1 Although the tempo-orbital region is the most often involved in pervasive developmental disorders abnormal functioning of the frontal cortex is suspected from replicated findings of executive function deficits and from occasional findings of frontal hypometabolism or abnormal macroscopic brain morphology. Abnormal cell counts and morphology in the cerebellar hemispheres have also been reported, but the relation of these findings to autism is controversial.2 Fah’s disease consists of symmetric calcifications, located mainly in the basal forebrain and cerebellum, which are of various etiologies. Cognitive and behavioural abnormalities may be present when calcifications occur early in development. A fortuitous association between pervasive developmental disorder and hypoparathyriodism, given the paucity of published cases, is plausible in the presented patient. Nevertheless, our case suggests that abnormal phospho-calcium metabolism could produce an autistic syndrome when brain calcifications cause specific neuropsychological deficits, due to their localisation. For example, errors of social judgement may be related to calcifications of the orbitofrontal cortex, whereas dysfunction of frontal-basal ganglia circuits may contribute to repetitive and ritualistic activities. Additionally, developmental lesions of the basal ganglia and cerebellum may contribute to the abnormalities of sensory attention, procedural learning, and motor intention in this patient.

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Selective hemihypaesthesia due to tentorial coup injury against dorsolateral midbrain: potential cause of sensory impairment after closed head injury

A 63 year old woman who fell off her bicycle had a left temporal region head injury with evidence of initial loss of consciousness of 5 minutes and scalp excoriation of that area. On arrival at our hospital 30 minutes later she was alert and oriented. Cranial nerve functions, including extraocular motion and hearing function, were preserved. Pain and temperature sensations of the right side, including her face, showed a 70% decrease compared with the left side; however, position and vibration sensations were normal. Other neurological examinations, including motor function, coordination, and deep tendon reflexes, were normal. The patient’s only complaints were left temporal headache and right hemihypaesthesia.

Brain CT on admission showed a discrete and linear high density at the left ambient cistern without other intracranial lesions. On the next day CT showed an obscure low density lesion at the dorsolateral midbrain in addition to the previous lesion (figure).

Brain MRI, taken 3 days later, demonstrated an intraparenchymal lesion, at the surface of the left dorsolateral midbrain in high intensity on a T2 weighted image. The high intensity lesion corresponding to haematoma on CT was seen in the ambient cistern (figure). Taking both CT scans and MRI into consideration, this case was diagnosed as traumatic midbrain contusion.

The loss of pain and temperature sensation improved gradually and the patient was discharged 2 weeks later.

T2 weighted images 1 month later showed a more localised lesion in the same area. The coronal slices showed a high intensity lesion at the level of lower midbrain coinciding with the tentorium level, disclosed as a low line between the occipital lobe and the cerebellar hemisphere (figure).

The neurological deficits almost disappeared 6 months later.

Somatosensory impairment including pain is one of the most common complaints among patients with craniocevical injury. Responsible lesions for sensory impairment, detectable by neuroimaging studies, almost always accompany associated neurological deficits. To our knowledge, a selective injury at the spinothalamic or trigeminothalamic tracts due to closed head injury has not been highlighted in the neurological literature.

The lesion shown in our MR images corresponded to haematoma on CT was seen in the ambient cistern in the axial image. (arrow head)

The MR images in our case showed a discrete lesion at the left dorsolateral midbrain. Topographical study at this lower midbrain level showed that the lateral and ventral spinothalamic and ventral trigeminothalamic tracts pass at the surface of this level by carrying a superficial somatosensory sensory input. The lesion shown in our MR images seemed to be localised to these tracts. The medial lemniscus for the deep sensation and lateral lemniscus and nucleus of inferior colliculus associated with hearing function run ventral and dorsal to these tracts, respectively, which were seemingly spared in our patient. The topographical anatomy seemed to correspond to the neurological manifestations of our patient.

The mechanism of midbrain injury in our patient was speculated to be due to tentorial coup injury based on MR images. The location of contusion was at the lower dorsolateral midbrain, coinciding with the tentorial edge level. Initiation of injury was the surface of the midbrain; however, due to the proximity of the tentorial edge to the midbrain on the injured side, tentorial contact to the midbrain supposedly occurred more readily. Brain MRI findings support the anatomical features of this tentorial coup injury. This injury is not rare in patients with severe head injury, accompanied by other intracranial lesions, and is often caused by lateral displacement of the brain stem relative to the tentorium. It is influenced by congenital variation in the size and shape of the tentorial incisura. The brain stem of the patient with a narrow incisura is more vulnerable to the direct contusive effects than that of a patient with a wider incisura. Therefore, even in minor head injury, this mechanism may occur in patients preconditioned with narrow tentorial incisura, which may have been the case in our patient.

The concept of tentorial coup injury against the midbrain is not new. It usually accompanies various degrees of conscious disturbance and other long tract signs, sensory deficits as well as cerebellar and cranial nerve palsy due to the midbrain lesion or other associated intracranial lesions. The clinical manifestation of our patient may represent one of the mildest forms of the midbrain contusion. Therefore, when we see a patient with post-traumatic sensory deficit, the possibility of this tentorial injury should be kept in mind even in minor head injury.

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(A) CT on admission showed a discrete and linear high density at the left ambient cistern. (B) Axial T2 weighted image taken 3 days later showed an intraparenchymal lesion, at the left postero-lateral midbrain in high intensity. (arrow). The margin was rather obscure. The high and low intensity lesion corresponding to haematoma on CT was seen in the ambient cistern in the axial image. (arrow head) Taking both CT scans and MRI, this case was diagnosed as traumatic midbrain contusion. (C) An axial T2 weighted image 1 month later demonstrated a more discrete lesion at the dorsolateral midbrain tegmentum (arrow). (D) A coronal image showed a discrete high intensity lesion at the level of lower midbrain (arrow) coinciding with the level of the tentorium, which was shown in low line between the occipital lobe and cerebellar hemisphere. The distance between the tentorial margin and brain stem was shorter on the injured side.
CORRESPONDENCE

Toluene induced postural tremor

We read with interest the article by Miyagi et al and comment on the medical treatment of toluene induced tremor. Microdialysis experiments in rats have shown that inhalation of toluene increases extracellular γ-amino butyric acid (GABA) concentrations within the cerebellar cortex which probably explains why GABA agonists including benzodiazepines (for example, clonazepam) are not very effective in toluene induced tremor and ataxia. Rat experiments also showed a 50% reduction in brain catecholaminergic neurons. Degeneration of certain cerebellar pathways is probably responsible for the loss of this dopaminergic innervation. Dopamine agonists could therefore be of potential interest in the treatment of toluene induced tremor. This hypothesis was explored in a recently described case, which showed remarkable clinical and iconographic similarities with that described by Miyagi et al: (a) long history of chronic toluene inhalation, (b) marked postural tremor, (c) progressive worsening of the symptoms despite abstinence from inhalant misuse, and (d) mild cerebral atrophy and marked low signal intensity in globus pallidi, thalami, red nuclei, and substantia nigra on T2 weighted MRI. As our patient’s tremor was progressive, medical treatment with a dopamine agonist was considered. One particular agent (amantadine) caught our attention because it had proved successful in the treatment of postural tremor in patients of heredodegenerative disorders in which the dentatorubro-olivary system is affected. In addition, there is evidence that catecholaminergic pathways are also involved in this type of ataxias, supported by loss of several of these neurotransmitters in the CSF of patients with heredodegenerative ataxias. In our patient, amantadine hydrochloride (100 mg twice daily) abolished the tremor.

Early diagnosis of subependymal giant cell astrocytoma in children with tuberous sclerosis

Nabbout et al have attempted to identify the risk factors for the progression of subependymal nodules into giant cell astrocytomas (SEGAs) in tuberous sclerosis complex. In attempting to develop screening strategies that avoid iatrogenic morbidity, patient inconvenience, and excess cost, it is essential that the natural history of these lesions in the general population of patients with tuberous sclerosis complex be understood well.

We think that there are two problems with this study that should make the physician cautious about accepting the factors identified by Nabbout et al as a basis for a screening programme. The first is that this study was conducted in a population that had been referred to a tertiary medical centre, and then had been further selected by virtue of having had at least 3 years tertiary centre follow up and needing two MR scans of the head. The prevalence of astrocytomas and risk factors, and hence the positive predictive value of any screening tool in a general population of patients with tuberous sclerosis complex is likely to be different from those described in the highly selected group studied in this paper. The second is that the authors have made a potentially misleading decision to exclude more than half their study sample because they do not have lesions close to the foramen of Monroe. It is not certain that all SEGAs arise from lesions close to the foramen. They may arise in the fourth ventricle. Furthermore, the late presentation of many lesions in the lateral ventricles has, in the past, precluded accurate determination of their point of origin. The study selects 24 of 60 patients who had met their entry criteria but does not state how many of the excluded 36 patients had no subependymal nodules or nodules that were not “near the foramen of Monroe”. Inclusion of the “near” criteria is given for what constitutes proximity to the foramen. The authors were apparently not blinded at the point when they selected which patients had lesions near to the foramen and therefore there is an obvious issue of potential selection bias.

The consequence of excluding these patients may have been that false significance is given to their results. The data they present are fragile. Consider, for example, the consequence of introducing from these 36 non-selected patients a hypothetical single case that had a family history of tuberous sclerosis complex and a subependymal nodule which enhanced with gadolinium. The effect would be to remove the stated statistical significance (using Fisher’s exact test) between the outcome and both of these explanatory variables.

Identifying the risk factors that can tell us whether subependymal lesions will become invasive is important. As subependymal nodules and SEGAs seem to be histologically identical it is unlikely that pathologists will provide an answer. The study of Nabbout et al suggests some new hypotheses, but raises rather than answers some others. However, the definitive answer will not be provided by studies of selected samples but by follow up of a population based sample of patients with tuberous sclerosis complex. In the absence of such a study we would be cautious about implementing screening programmes based on what may be misleading criteria.

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Atypical form of amytrophic lateral sclerosis: a new term to define a previously well known form of ALS

We read with interest the article by Sasaki et al concerning the atypical form of amyotrophic lateral sclerosis (ALS). The pattern of muscular atrophy in these patients differed from that of typical ALS in that severe muscle involvement was confined to the upper limbs, predominantly the proximal portion and shoulder girdle, sparing the face and the legs until late in the disease’s course or until the terminal stage.

Over the past few years, we have noticed a growing interest in the renaming of this clinical form of ALS, which has its origins and predomination in the proximal muscles and upper limbs and little or no effect of either a bulbar nature or in the lower limbs.

Thus Hu et al coined the term flail arm syndrome, to describe a subgroup of patients affected by ALS that predominantly showed signs of lower motor neuron disease in the upper limbs, without significant functional involvement of other regions on clinical presentation. This subgroup of patients was clinically characterised by the display of progressive atrophy and weakness affecting the proximal muscles in the upper limb muscles in a more or less symmetric manner.

Recently, along these lines, Kata et al described a series of patients affected by an adult onset motor neuron disorder restricted to the upper limbs, with severe proximal and varying degrees of distal involvement, calling it amytrophic brachial diplegia syndrome.

Other terms used in the past to refer to this form of ALS have been dangling arm syndrome, suspended form, orangutan sign, dead arm sign, bibrachial palsy, rizomelic amyotrophy, and the idea of naming it a distinctive phenotype of a neurogenic


“man-in-the-barrel” syndrome has even been suggested. Probably all these terms used to define this variation of ALS are synonyms for an older, well known condition, the scapuloulcer form, or the chronic anterior poliomyelitis reported by Volkmann in 1886 and known in Franco-German literature as Vulpen-Bernhardt’s form of ALS. At certain stages of the disease’s clinical course, it is probably difficult to differentiate it from progressive muscular atrophy (PMA). Some authors have said that PMA with late onset scapuloulcer distribution (over 45 years of age) generally leads to ALS as a matter of course.

Be that as it may, the truth is that this atypical form of amyotrophic lateral sclerosis behaves differently from typical ALS. The comparative study with the rest of the ALS group supplied important clinical findings, such as little or no functional impairment of the bulbar muscles or legs. Hu et al also made four important statistical discoveries.

1. The prevalence of this form of ALS constituted 10% of the ALS group as a whole (p = 0.05). (2) The age of onset of this form was similar to the rest of ALS. (3) There was a clear predominance among men (the male/female ratio was 9:1 in this form, compared with 1.5:1 in the total ALS group). (4) There was a longer median survival (a median survival of 57 months compared with 39 months in the ALS group).

Some of these patients have a long ALS clinical course, in that they usually preserve ambulatory ability, albeit with gait disorders, for over 5 years after the onset of symptoms.

On a personal level, we also note two findings characteristic of these patients. In the initial stages of the illness, there is no evidence on the diaphragm and the respiratory muscle failure occurs much later than in the typical form of ALS. This can be seen in the follow-up of the results obtained in the respiratory function tests (FVC, PImax, and PEmax).

We do not know the reason for either the characteristic distribution of weakness or muscle atrophy. A meticulous study shows that there is an atrophy of the deltoides (especially in the pars spinata) and a lack of strength in the external rotation of the shoulder (infraespinitas, supraespinatess, and teres minor). As a consequence, the upper limbs adopt a characteristic position, with the shoulders slumped, and the arms, forearms, and hands in pronation.

The atrophy and weakness of the infraspinitas and the supraspinitas, that act as an active ligament in scapuloulmeral articulation, would explain the presence of subluxation of the shoulder joints in these patients.

Finally, we are in complete agreement that the problem of cervical spondylosis and ALS can cause difficulty in diagnosis. The problem lies in the fact that cervical spondylosis is a common condition. It is found in 83.5% of men and 80.7% of women over the age of 55. The faster progressive deterioration of the symptoms, the appearance of bulbar signs, and the absence of sensory symptoms and signs would favour the diagnosis of ALS.

Isolated dysarthria

We read with interest the article by Urban et al. Using transcranial magnetic stimulation, the authors demonstrated electrophysiologically evidence for a central monoparesis of the tongue in patients with isolated dysarthria from stroke.1 As in their patients transient magnetic stimulation induced absent or delayed corticobulbar responses at the tongue, the authors ascribed isolated dysarthria to interruption of the corticobulbar pathways.

On the whole, their work is plausible, but we would like to comment on the underlying mechanism of isolated dysarthria.

As in the case of isolated dysarthria reported by Urban et al, all of our patients with isolated dysarthria had lacunar infarctions involving the internal capsule and corona radiata. Measurement of cerebral blood flow with IMP-SPECT in these patients disclosed frontal cortical hypoperfusion, particularly in the anterior opercular and medial frontal regions. Anterior opercular lesions produce facio-pharyngo-glosso-masticatory paresis (anterior opercular syndrome), and damage to the medial frontal regions, including the supplementary motor area, causes speech expression disorders. White matter lesions can disrupt afferent and efferent fibre connections in motor and motor-sensory areas, resulting in dysfunction of these cortices. Therefore, we postulated that isolated dysarthria results from interruption of corticosubcortical networks indispensable for speech output, involving the thalamocortical and corticostratial fibres as well as the corticobulbar fibres. In fact, lacunar infarctions around the internal capsule-corona radiata are likely to underlie these ascending and descending projections.

To assess corticopontocerebellar tract function, Urban et al investigated cerebellar blood flow in patients with isolated dysarthria using HMPAO-SPECT. They postulated that isolated dysarthria included that the corticopontocerebellar tract is preserved in isolated dysarthria because of no evidence for cerebellar diaschisis on SPECT. Their SPECT findings on cerebellar blood flow were similar to our results. However, we wonder whether cerebral cortical blood flow was preserved in their patients, because our SPECT study suggested frontal cortical dysfunction as an underlying mechanism of isolated dysarthria. Lingual pathological aspects were evident in three of seven patients reported by Urban et al and in two of 12 by us. This indicates that isolated dysarthria originates in incoordinated multiple organs necessary for articulation as well as a cerebellar impairment. Although interruption of the cortico-motor pathways is a likely cause of isolated dysarthria, it should be borne in mind that damage to other descending and ascending projections may contribute to isolated dysarthria.


Urban et al. reply: Okuda et al draw attention to their article on pure dysarthria in Stroke which we read with much interest. They refer to 12 patients with pure dysarthria, 11 of whom showed multiple bilateral infarctions involving the internal capsule and corona radiata. The main difference to our series of seven patients is the multiple involvement of the brain. We think the single lesion is as collected by us a more appropriate approach to correlate lesion topography with impaired function. The findings of Okuda et al are in line with our conclusion that interruption of the corticolingual pathway is the pathogenesis of dysarthria of extracerebellar origin. Obviously, impairment of the corticolingual tract of one hemisphere by a single small lesion is an adequate condition for dysarthria. The patients of Okuda et al may be due to infarction in other parts of the brain compared with the lesion causing pure dysarthria.

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Motor cortical excitability in Huntington’s disease

We read with great interest the paper of Hanajima et al reporting that intracortical inhibition of the motor cortex is normal in patients with chorea of various origins. At variance with their results we previously found a reduced intracortical inhibition in a group of patients with genetically confirmed Huntington’s disease. Hanajima et al suggest that the discrepancies between the two studies may be due to a difference in patient selection as they included patients with early stage Huntington’s disease to “study the pathophysiology of chorea unaffected by other disorders movement.” They postulated that our cases, because of the reported corre-
intracortical inhibition is often decreased even in normal subjects. The 90% of the threshold for relaxed muscles must correspond to different values relative to the threshold for active muscles in patients from that in normal subjects. (2) The intracortical inhibition is disturbed in Huntington’s disease. This slight abnormality could be detected with their method but not with ours because their method has better sensitivity in detecting an abnormality than ours. Whether is true, the intracortical inhibition must be normal or slightly disturbed in Huntington’s disease.

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Critical closing pressure: a valid concept?

Czosnyka et al. recently published a study investigating the clinical significance of critical closing pressure (CCP) estimates in patients with head injury. We see problems both with the theoretical foundation of their CCP concept and with the interpretation of their results.

Firstly, the physiological meaning of both formulae of CCP presented (CCP1 and CCP2, respectively) is questionable. The implication of both presented equations is that the instantaneous value of cerebral blood flow velocity (FV(t)) at a given moment is equal to arterial blood pressure at the given time (ABP(t)) minus CCP divided by cerebrovascular resistance (CVR):

\[ FV(t) = \frac{(ABP(t) - CCP)}{CVR} \]  

(1)

At the time of systolic and diastolic peak flow velocities (ABP, FVp), respectively, it follows that systolic and diastolic flow (FVs, FVd) should be equal to (ABPs-CCP)/CVR and (ABPd-CCP)/CVR, respectively. However, it is still unknown how the vascular resistance valid for the static pressure/flow connection (CVR0) concerning mean pressures and flows) is different from and is in general much higher than resistances determining dynamic pressure/flow relations (CVR1) as the case of pulsatile flows. Therefore, equation 1 cannot be applied to describe dynamic flow. This can best be illustrated using the frequency domain approach (ABP=mean pressure; FV=mean flow velocity; F1=amplitude of the pulsatile pressure wave; CCP=critical closing pressure).

\[ FV(t) = \frac{(ABP(t) - CCP)}{CVR} \]  

(2)

Inserting equations 2 and 3 into the frequency domain equation for CCP2 of the authors:

\[ CCP2 = \frac{A1}{F1} \]  

(4)

leads to

\[ CCP2 = \frac{ABP - CVR1 \times CVR0}{\frac{(ABP - CCP)}{CVR \times CVR0}} \]  

(5)

Observe that CCP2 is only in the case of CVR1=CVR0 equal to CCP. Under the more realistic assumption that CVR1 is equal to about half of CVR0 it follows for CCP2:

\[ CCP2 = \frac{0.5 \times ABP - 0.5 \times CCP}{\frac{(ABP - CCP)}{CVR \times CVR0}} \]  

With decreasing CVR1/CCP ratios, CCP2 becomes more and more dependent on ABP and independent of CCP. In any case, without exact knowledge of the CVR1/CCP ratio, equation 4 is useless for a valid CCP calculation.

The second criticism concerns the correlation of the calculated CCP values with the ABP found by the authors (r=0.5; p<0.05). According to the original idea of Burton, CCP represents a certain mean ABP value below which small vessels begin to collapse. CCP should, therefore, be a constant value independent of the actual ABP. On the other hand, this significant correlation can be explained by our equation 5, again indicating the missing physiological basis of the CCP concept of the authors.

Thirdly, it seems doubtful that CCP could be estimated using pressure and flow values from ABP ranges clearly above CCP and flow values clearly above zero flow, respectively. As long as small vessels do not collapse (ABP>CCP) it is not possible to decide whether their actual wall tension is determined more by transmural pressure or by active vasomotor constriction. However, the relative contribution of both effects is critical for the limit of CCP.

Finally, I would be interested in the authors’ explanation of negative diastolic flow values as seen in Doppler spectra of arteries with a high vascular resistance (peripheral arteries, middle cerebral artery during strong hypocapnia). In the case of ABP<CCP and a small vessel collapse according to the model of the authors, CVR should increase towards zero and FVd towards zero (equation 1). Negative flow values could, consequently, not occur. I suggest that the relation between pulsatile pressure and flow should be better described using the concept of different static and dynamic resistances (CVR0 and CVR1). The driving pressure of the mean FV is more accurately given by cerebral perfusion pressure (CPP=ABP-ICP) than by ABP-CCP. Therefore, equation 2 changes to

\[ FV(t) = \frac{(ABP(t) - ICP)}{CVR} \]  

(6)

and equation 5 to

\[ CCP2 = \frac{ABP(t) - CVR1(t) \times CVR0(t)}{\frac{(ABP(t) - CCP)}{CVR(t) \times CVR0(t)}} \]  

(7)

Equation 7 explains well the positive correlations found between CCP2 and ABP and between CCP2 and ICP, respectively, without assuming a connection between CCP2 and Burton’s concept of “critical closing pressure”.

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risks. How risky—we can see from Dichi’s letter. Cerebrovascular resistance certainly never increases to infinity, only after death. We fully agree with the considerations regarding equations (6) and (7). CCP can be treated as an asymptote, and the limit of the integral of the function representing the cerebral vascular bed. Whether it simplifies our understanding—we personally find it doubtful. Finally, we are truly obliged to Dichi for an opportunity to have this interesting discussion.

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High frequency stimulation of the subthalamic nucleus and levodopa induced dyskinesias in Parkinson’s disease

Reduction in the neuronal activity of the subthalamic nucleus leading to diminished excitation of the globus pallidum internum is associated with chorea-ballism in monkeys. Levodopa induced dyskinesias are currently thought to share a similar pathophysiology but recent findings also suggest that abnormal patterns of neuronal firing in the globus pallidum internum may be as relevant. Data from both parkinsonian monkeys and patients with Parkinson’s disease submitted to lesion or functional blockade of the subthalamic nucleus are in keeping with such a general principle, but the threshold to induce dyskinesias in the parkinsonian state is higher than in intact animals. The case recently described by Figueiras-Mendez et al. is extremely interesting as it suggests that functional inhibition of the subthalamic nucleus by high frequency stimulation blocks levodopa induced dyskinesias. This is clearly at odds with the current pathophysiological model of the basal ganglia. Thus, the finding of Figueiras-Mendez et al. rises the intriguing possibility that dyskinesias depend or are mediated by neuronal firing in a given region of the subthalamic nucleus, which was blocked by high frequency stimulation. Measurement ofafferent synaptic activity by the technique of 2-deoxyglucose (2-DG) uptake showed an increment in the subthalamic coefficients describable with increased inhibition from the globus pallidum externum, particularly in the ventromedial tip of the nucleus. This supports the findings in monkeys with chorea induced by pharmacological blockade of the globus pallidum externum, in which 2-DG uptake was maximal in the dorsolateral portion of the subthalamic nucleus, where the sensorimotor region lies. A recent anatomical study also showed that the cortical-subthalamic and caudate-con

neous is somatotopically segregated, so that fibres from the supplementary motor area project to the most medial portion and fibres from the primary and premotor areas terminate in the lateral region of the subthalamic nucleus. All this heterogeneity may have pathophysiological relevance, being one aspect of which could be the findings in the patient reported by Figueiras-Mendez et al. However, before the findings of this case may be used to sustain or challenge the hypothesis on the role of the subthalamic nucleus in the origin of levodopa induced dyskinesias, there is a crucial issue to resolve—namely, the location of the tip of the stimulation electrodes.

There are several points leading us to question the actual site of action of the electrode. (1) Stimulation of the subthalamic nucleus in Parkinson’s disease has been associated with the production of dyskinesias only with reduced dyskinesias in levodopa intake. Moreover, Benabid et al who pioneered this technique, consider the induction of dyskinesias by high frequency stimulation of the subthalamic nucleus as a good indicator of a very positive response to DBS. This is falling to the thalamus from the globus pallidum internum are placed dorsocaudally to the subthalamic nucleus and could be blocked by high frequency stimulation. (2) When the recording electrode is placed ventromedially to the subthalamic nucleus in sagittal planes 11 mm or less, neuronal activity is characterised by action potentials of large amplitudes (0.5–1 mV) with low background activity, tonically firing neurons, and absent sensorimotor responses (“driving”). All these characteristics seemed to be present in the patient discussed here. Neuronal activity in the sensorimotor region of the subthalamic nucleus is different from the above but on occasions the distinction may not be easy. It is extremely important to document in more detail the findings in the case of Figueiras-Mendez et al. Ideally, we would like to see the trajectory and length of the different recording tracks, the effects of microstimulation, and the posturgical MRI with measurement tracks, the e of the electrodes. If, as assumed, the subthalamic nucleus was indeed correctly targeted in this patient, the pathophysiology of the basal ganglia will need to be revisited.

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Figueiras-Mendez et al. reply We thank Obeso et al for their comments regarding our recent report. In summary, they raised some interesting points which need further clarification.

Recognition of the electrical activity of the subthalamic nucleus was based on the following criteria: (a) high frequency discharge (25 Hz or higher) within the nucleus; (b) a tonic (regular), phasic (irregular) or a rhythmic pattern of discharge; (c) response to voluntary/purposeful movements. When rhythmic discharge were recorded irregular passive manipulations were performed or the patient asked to move the limbs regularly; (d) response to tremor activity. Positive cells were considered based on the correlation with the EMG and the accelerometer recorded simultaneously. Artificial manual stoppage by one experimenter (confirmed by visual inspection, silence in the EMG, and stoppage in the oscillating accelerometer) and/or spontaneous arrest in the tremor modified the firing frequency and discharge pattern or rhythmic cells corroborating the tremor nature of the cells; (e) the activity of the cells above the subthalamic and zona incerta with proper characteristics; (f) a change in the background basal noise when entering the subthalamic nucleus. A higher activity is observed; (g) a change in the background basal noise when entering the subthalamic and zona incerta with proper characteristics; (h) the activity of substantia nigra pars reticulata cells when further lowering the microelec
tode. These cells discharge at high frequency at regular intervals as identified in patients and in primates. All these points were fulfilled by the patient reported.

Considering the questions in the letter by Obeso et al, we make the following comments: (a) Action potentials of rhythmic discharge are easily recognised from the rest of the recording cells, and are not very common. The recordings shown in the article have amplitudes less than 0.3 mV and could not be considered large amplitude potentials. We start to record activity from 3 mm before entering the subthalamic nucleus, traverse the length of the subthalamic nucleus, and go further down several mm to encounter substantia nigra pars reticulata cells. Changes in the background activity are clearly recognised and are higher when entering the subthalamic nucleus. Enough cells are recorded along the tracks experimented so as to recognise a large amplitude potential. The
low background activity found in our recordings is only due to the better signal-to-noise ratio of the electrodes used. “Good recording electrodes” depend on many variables such as tip size, tip profile, insulation material, impedance, manufacture, etc. The signal-to-noise ratio of the cells in question has the same ratio as the subthalamic nucleus cell shown by Hutchinson et al.

(b) In our report, cells discharged tonically, but in the figure they discharged phasically. This is well differentiated by a profuse burst activity and identified by statistical means (autocorrelation and interval histograms).

(c) Motor responses and tremorgenic cells in line with the above mentioned criteria were found along the trajectory of the electrode. Unfortunately, this point was not mentioned in the paper. It would surely have changed the opinion of Obeso et al.

At the diffused patient, a total of eight neurons were recognized as belonging to the subthalamic nucleus in the right hemisphere, with a mean frequency of 74 Hz (range 38–109 Hz). Four of them responded to passive and/or voluntary movements and one was considered tremorgenic. The stimulating electrode was placed at a height of 6–6.5 mm below the intercommisural line, and (b) height: 6–6.5 mm below the intercommisural line, and (c) lateral: 12 mm for the right hemisphere, and 11.5 mm for the left hemisphere.

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Nitrict oxide in acute ischemic stroke

The pivotal role of nitric oxide (NO) in cerebral ischemia has been elegantly highlighted in the recent editorial by O’Mahony and Kendall. Although studies of neuroprotective agents have been largely disappointing, pharmacological manipulation of NO may represent a novel means of protecting the brain from ischemic insult. One area not discussed in the editorial is the neuroprotective effect of 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors or “statins” in cerebral ischemia. Preliminary studies have shown that statins modulate brain nitric oxide synthesis and may have anti-convulsive activity in a neuroprotective manner. Data from a murine model of ischemic stroke demonstrate that prophylactic statin therapy reduces infarct size by about 30%, and improves neurological outcome in normocholesterolemic animals. In this investigation, statin therapy directly regulated endothelial NO in the brain without altering expression of neuronal NO. Recent findings also suggest that statin therapy influences the actions of inducible NO. Lovastatin has been shown to inhibit cytokine mediated upregulation of inducible NO and production of NO in rat astrocytes and macrophages, and this inhibition may represent a significant suppressing inflammatory responses that accompany ischemia. Most interestingly, these preliminary findings suggest that statin therapy may modify the friendly and unfriendly faces of brain NO in a synergistically neuroprotective manner. These and other vascular effects of statins in cerebral ischemia are potentially of great importance in human neuroprotection and ongoing clinical trials the The Prospective Study of Pravastatin in the Elderly at Risk (PROSPER) study will help clarify their role in human cerebrovascular disease.

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O’Mahony replies:

The comments of Vaughan and Delanty draw attention to the act of narrating might detract from realistic illusion, so reducing the emotional intensity of what was being represented. It is a device much favoured by postmodern writers, who expose the nature of fictional constructs. The intrusive medical author never dropped out of fashion, although in these days of evidence based prejudice, authorial omniscience might be considered suspect. The authors of this volume are intrusive in a guiding conversational manner that makes this book by far the most readable of the neuroimmunological texts.

The book opens with a highly accessible chapter on immune responses in the CNS, a chapter which quickly sets out the range of multiple sclerosis. The book then discusses the neuroimmunological texts.

The book opens with a highly accessible chapter on immune response in the nervous system. There follows a chapter that integrates the neurobiology of multiple sclerosis with contemporary issues of aetiology, cell injury, and repair. Next, a chapter on inflammatory demyelinating disease examines symptoms of isolated demyelination, acute disseminated encephalomyelitis and allied conditions, and some of the syndromes of demyelination that are now accepted as part of the range of multiple sclerosis. The chapters on demyelinating disease are drawn to a close by a discussion of existing and experimental therapies for multiple sclerosis.

The book continues with chapters on para-neoplastic disorders of the CNS, stiff man syndrome, neurological complications of
connective tissue disorders, organ specific autoimmunity, sarcoidosis, and cerebral vasculitis.

Each chapter is an appropriate length and well referenced; the wood is always clearly visible between the trees. This book is sufficiently readable and small to be recommended as holiday reading. Its only drawback is that in making erudition so readily available, one risks being outshined yet again by one's registrar.

JON SUSSMAN


As Alzheimer’s disease becomes of increasing importance to society, basic science research in this field needs to provide the building blocks for both therapeutic interventions and accurate diagnosis. This publication is a collection of papers presented at an international Alzheimer’s disease research meeting in Leipzig in 1997. This conference aimed to bring together both clinical and basic science disciplines and this is reflected in the papers selected for this book. There are 31 papers included, covering topics from early symptomatology and cognitive features to immunobiology and theoretical neuronal treatment strategies. The contributors to this book are some of the most authoritative in their field, predominantly based in Europe.

Covering all aspects of Alzheimer’s disease research from the correct diagnosis to basic science approaches of treatment is ambitious for such a compact book (315 pages), and although the editors succeed in collecting an interesting series of papers around these themes, they make no claims to be comprehensive in their scope. The papers included range from fundamental research reports to reviews of the current literature. The review papers are generally excellent, concise, clear, well referenced, and illustrated—for example, there are excellent reviews of Alzheimer’s disease with vascular pathology (Pasquier et al), and Lewy body disease (McKeith et al), great updates on neuropathology (Jellinger and Bancher, Braak et al), and several worthy reviews of treatment strategies for Alzheimer’s disease including NSAIDS (Moller), antioxidants, and radical scavengers (Rosler et al). I found the review by Reisberg et al on ontogenic models in the understanding of the management of Alzheimer’s disease particularly interesting. However, the papers of original research are of more limited interest to the general reader. Although, as mentioned, the quality of illustrations is good, there is some variability in the definition of abbreviations and occasional lapses into other European languages.

Certainly, I think this book would be of value for investigators interested in the neuropathology, immunopathology, and molecular biology of Alzheimer’s disease. It would make an excellent addition to libraries as a reference text for many researchers of varied interests.

CLARE GALTON


Organ transplantation, once medical exotica, is now almost commonplace in the United Kingdom each year are performed cadaveric organ transplants of about 1800 kidneys (in addition to 160 live kidney donors), 700 livers, and 450 heart/lungs (UK Transplant Support Service). Several basic surgical techniques were established at the beginning of the century in canine models. Translation of these experiments to humans awaited safe and effective immunosuppression. Various forms of immunosuppression were radiation (total body or total lymphoid) and non-selective chemical reagents (benzene and tolouene). Then the antipsilodrug drug 6-mercaptopurine (6-MP) was introduced, shortly followed by a derivative, azathioprine, with improved oral bioavailability. Combined with corticosteroids, these allowed the first human solid organ transplants to be performed: in 1954 the first lung transplant in Mississippi and liver transplant in Colorado. Then in 1967 Christian Barnard captured the world’s imagination with the first heart transplant. His technique has been modified slightly since, but the increasing success of organ transplantation rests mainly on improved immunosuppression with drugs that selectively suppress lymphocytes by inhibiting lymphokine generation (cyclosporin A, tacrolimus), renal transdution (sirolimus, lefunomide), or differentiation (15-deoxyspergualin) pathways. As a result, over the last 10 years in the United Kingdom, the 1 year survival of grafts has improved from 80% to 90% (kidney), 55% to 75% (liver), and 70% to 90% (heart/lung).

Wijdicks estimates that 10% of transplant patients have a significant neurological complication. While without common being neurotoxicity of immunosuppressive drugs, seizures, and failure to awaken. Yet this is the first text devoted to the neurological aspects of organ transplantation. It is therefore a timely subject for another title in the excellent Blue Books Of Practical Neurology series. Twenty authors contribute (one Dutch, one Swiss, the rest American) to four chapters on the transplant procedures themselves followed by 10 chapters on neurological complications of transplantation including failure to awaken, and psychiatric, neuromuscular and demyelinating complications. Especially useful to the neuroligist without much experience of transplantation are the comprehen.

roke chapters on immunosuppressive drugs and the opportunistic infections associated with them (most commonly Listeria monocytogenes, Aspergillus fumigatus, and Cryptococcus neoformans). The peripheral nerve and plexus injuries associated with transplantation are painstakingly described; astonishingly a signif.

icant ulnar neuropathy occurs in up to 40% of kidney transplant recipients, and 30% to 40% of heart/lung transplantation patients. The Cincinnati Transplant Tumour Registry has recorded information on 10 813 cancers arising de novo in organ allograft recipients worldwide and here are presented the data in the 300 of these with CNS involvement. This is one for the shelves of any neurologist involved in organ transplantation.

CLARE GALTON


Volume nine of the Current Issues in Neurodegenerative Disease series examines the interplay between cerebrovascular disease and dementia, particularly Alzheimer’s disease. Two hundred pages of what are essentially 20 brief review articles comprise this text, sadly without any illustrations. Fortunately the introduction to each chapter there is a certain sense of deja vu, although on the positive side each contribution is extremely well referenced.

The book is divided into five sections covering the historical concepts of vascular and Alzheimer’s dementia, the arguments for a pure vascular dementia, the role of Alzheimer’s disease in the genesis of dementia after stroke, the connections between white matter changes on neuroimaging to dementia, and finally a short section examining practical questions such as the management of stroke in patients with dementia.

Although common conditions in their own right, stroke and Alzheimer’s disease do seem to cross paths more often than would be expected by chance alone, and more often than can be explained by the presence of unproved angiopathy and recurrent subarachnoid haemorrhages. Perhaps common genetic factors are responsible and here the APOE alleles are discussed. The comprehensive section on deep white matter lesions seeks to explain the connection further—and convinces the reader that there is still a lot which is not well understood. It is in this section particularly that illustrations are greatly missed. Brief mention is made of other conditions which may produce white matter changes and dementia such as CADASIL, cerebral lupus, and the primary antiphospholipid syndrome.

Some typographical errors and mistranslations detract a little further from a book which seems unlikely to appeal to most neurologists, although it will no doubt be a source of reference to those working in the field of cognitive disorders, particularly vascular dementia.

PETER MARTIN


Evolutionary biologists would probably tell us that the enchantment of stories is due to survival having been dependent on the passing of oral culture from one generation to the next. Information put in narrative form not only delights, but is easily recalled. Stories also construct meaning by interweaving observation, inference, motive, and consequence in a fashion that informs future action. Our experience of the world is constructed around such narratives. They define us as individuals, family members, professionals, and cultural groups.

This book is a series of essays on psychotherapy, psychiatry, and also medicine that see the awareness and use of narrative in clinical practice as a construct that can both...
deliver effective care as well as act as a conceptual bridge between the different disciplines. One of the great pleasures of being a doctor has always been listening to patient's stories, but the editors of this book fear that this essential art can be overtaken by dull scientific dross.

The rest of this book is of variable quality. There is a rather prosaic essay on gender issues, and there is repetition in various chapters concerning attachment theory, a useful but over worked paradigm. However, there are also two very fine accounts of narrative in psychotherapy by James Phillips and Jeremy Holmes.

The book is essentially a collection of monographs of heterogeneous content and style and the result, perhaps not surprisingly, is that some of the component parts are better than the sum. The clinically oriented sections will clearly be of particular interest to those who treat children and their families. The chapters on infantile spasms and Lennox-Gastaut syndrome are informative and provide some new but speculative insights into the pathogenesis of spasms. However, it was surprising that severe myoclonic epilepsy of infancy did not merit a specific chapter in view of the unique electroclinical and natural history of this syndrome. The crucial issue of the cognitive and behavioural sequelae of early and frequent seizures on the immature brain, which is probably of most concern to both clinicians and families, is succinctly addressed in two chapters—although a clear and consistent causation and effect relation remains to be established. The chapters covering basic neurophysiology, neurochemistry, and neuropathology, are erudite and fascinating but at times are comprehensively. Further work is needed, including answering the fundamental question—why does the first seizure occur?—before the clinician and basic scientist are able to talk the same language—ironic for the benefit of the patient with epilepsy.

The concept of Childhood Epilepsy and Brain Development is innovative and commendable and a number of the monographs are interesting and informative, the overall impression is that the individual parts (the chapters) are better than the whole (the book). The lack of an index is a strange omission, perhaps reflecting a prolonged editorial atypical apathy, and although this militates against it becoming a well-thumbed reference text, the book is an erudite addition to the mossy fibre-like sprouting of the epileptological literature.

RICHARD E APPLETON


Difficult clinical problems in psychiatry come in many forms. Diagnosis often causes difficulty, particularly in cases which demand some assessment of the role of physical illness in symptom formation. Perhaps for most psychiatrists practising in community settings risk assessment comes high on their list of concerns.

Unsurprisingly, given the psychopharmacological expertise of the editors, this book is particularly interested in treatment resistance. The first 6 chapters give excellent reviews of the management of clinically relevant topics—for example, refractory schizophrenia or the difficult panic patient. The emphasis is very much on pharmacological management.

The second half of the book is more of a mixed bag, both in terms of the areas covered and the quality of the chapters. There are a few cavils. The section on chronic fatigue syndrome is a very good account of the management of hyperactivity in childhood, with good practical advice on the use of methyphenidate.

Apart from the chapters on chronic fatigue and the treatment of tardive dyskinesia there is little in this book which is of immediate interest to neurologists. However general psychiatrists wishing to improve their prescribing skills will find this book useful.
Fahr's disease and Asperger's syndrome in a patient with primary hypoparathyroidism

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