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 ganglion. 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 Antiepileptic drugs were withdrawn to facilitate seizure recording.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 of brief psychotic disorders without marked stressor. HMPAO-SPECT was performed during the psychotic period, which ranged from 2–4 days after the last seizure. Interictal cerebral SPECT, brain MRI, and a Wada test were performed as part of presurgical evaluation.

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. Interictal cerebral SPECT showed a relative hyperperfusion area over the left hemisphere. Interictal 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 hyperperfused 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 asymmetry index (ASI) was calculated as ((ROI focus−ROI contralateral)/ROI focus+ROI contralateral)×200%. 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 company with their interictal study (figure). Quantitative analysis for patient 1 showed changes of ASI during IP and PP over right MT was +75% (-6.46476 to -1.65288); over the right LT was +116.7% (1.07927 to 12.54764); and over the left BG was +206.8% (-2.07373 to 2.21574). Quantitative analysis for patient 2 showed changes of ASI during IP and PP over right MT was −3.8% (13.14217 to 12.64158); over right LT was +178.6% (10.4696 to 18.7007); and over left BG was +155.9% (−5.85556 to 3.27522).

Postictal psychosis is a distinct clinical event associated with temporal lobe epilepsy.4 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 clinical seizure and is not partial seizures precipitated by abrupt withdrawal of antiepileptic drugs.5 The cluster occurs in patients with poor drug compliance or during video EEG telemetry studies when antiepileptic drugs are withdrawn purposefully. The typical clinical course of postictal psychosis is usually benign and predictable.6,7 In our patients, the duration of psychiatric disturbances lasted from 1 to 7 days, which is in keeping with the good prognosis. Antipsychotic drugs, such as haloperidol and fluphenazine are usually prescribed.8

The underlying mechanism of postictal psychosis is unknown. Postictal cerebral hypofunction has been postulated as an analogue to Todd's paralysis after seizure.9,10 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.11

To conclude, our results are contradictory to the hypofunction theory of Todd's paralysis in postictal psychosis. We think that these hyperperfusion areas are responsible for the postictal psychosis. Further serial studies with cerebral SPECT or PET may enhance our understanding on the mechanism of postictal psychosis.

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<thead>
<tr>
<th>Anti-FN mAb1</th>
<th>Anti-TN Ab fragments1</th>
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<tr>
<td>IST-4</td>
<td>IST-9</td>
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<tr>
<td>BC-1</td>
<td>TN-12</td>
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<td>TN-11</td>
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Characterisation of the employed Abs and distribution of the recognized isoforms.
Previous findings showed that ED-B+F on vessels 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+F 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 glialomas.

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.

Furthermore, use of the cell proliferation marker MIB-1 showed endothelial proliferation in arterioles, venules, and capillaries of the cerebral tissue neighbouring AVMs.

The present findings indicate that a particular FN isoform, mainly expressed by the vasculature of fetal and tumorous tissues, as well as a TN isoform typically detected in the walls of vessels in anaplastic gliomas, also occur in AVMs and in vessels of adjacent cerebral tissue, but that both isoforms are absent in normal brain. This evidence provides further support to the hypothesis of ongoing angiogenesis in and around these lesions.

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 pathogenic 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. This 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, it is likely that 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 ease 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.
began aggressive and threatened them with a saw. The general practitioner was called and subsequently admitted a new Tyson, and a severe depressive illness. Police assistance was requested because of the patient's continuing violent behaviour.

On admission he was unkempt but cooperative and appeared friendly. 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 psychotic phenomena. He was agitated 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 and relatively circumscribed neuropsychological deficits associated with high anti-thyroid antibody titers: report of 5 cases in general 1991;4:228–33.

Alien hand sign in Creutzfeldt-Jakob disease

The clinical picture of Creutzfeldt-Jakob disease (CJD) includes various movement disorders such as myoclonus, parkinsonism, hemiballism, and dystonia. 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.


The mild and relatively circumscribed neuropsychological deficits coupled with florid psychotic phenomena, also contrast with the profound global disturbance of cognition usually associated with Hashimoto’s encephalopathy. Although the present case does not meet the diagnostic criteria of CJD, the most common being Creutzfeldt-Jakob disease, one of the human prion diseases, is characterised by rapidly progressive mental and motor deterioration. Involuntary movements occur in above 90% of the patients in the course of the disease, the most common being myoclonus. Other movement disorders range from tremor to chorea, dystonia, and hemiballism. 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 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, ocipitotemporal lobe, and thalamus, 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 prior to 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 1 Laboratory and neuropsychological results at presentation (A) and at 12 month follow up (B)

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<thead>
<tr>
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<th>A</th>
<th>B</th>
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<tr>
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<tr>
<td>Erythrocyte sedimentation rate</td>
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</tr>
<tr>
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<td>Negative</td>
</tr>
<tr>
<td>B12 and folate</td>
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<tr>
<td>VDLR</td>
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<tr>
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<td>Free T4 (pmol)</td>
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<td>Psychometric (normal/predicted range):</td>
<td></td>
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<tr>
<td>Volklin MMSE (&gt;24)</td>
<td>10th percentile 16th percentile</td>
<td></td>
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<tr>
<td>NART IQ</td>
<td>25</td>
<td>23</td>
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<tr>
<td>WAIS-R (verbal)</td>
<td>13th percentile 18th percentile</td>
<td></td>
</tr>
<tr>
<td>WAIS-R (performance)</td>
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<td>Not tested</td>
</tr>
<tr>
<td>FAS verbal fluency (&gt;30)</td>
<td>25</td>
<td>23</td>
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<tr>
<td>Cognitive estimate test (&lt;6)</td>
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<td>11</td>
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<tr>
<td>Digit span forwards (&gt;5)</td>
<td>10/30</td>
<td>16/30</td>
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<tr>
<td>Rey-Osterreth complex figure (copy) (36)</td>
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<td>23</td>
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<tr>
<td>Rey-Osterreth complex figure (recall) (30%)</td>
<td>Not tested</td>
<td>75%</td>
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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, bradypnic, and partially collaborative. His con-

sciousness, however, was disrupted by hallucina-

tions. The affect was sad and he had partial insight for his mental dysfunction. He was
disoriented for time, place, and situation. He could under-

stand speech and was able to fol-

low oral instructions involving two consecu-

tive components. Naming was preserved.

Prominent dysgraphia and dyscalculia were noticed. Immediate recall and short term memory were severely disturbed, whereas
term long memory, especially for personal life events, was relatively spared. Abstract think-

ing was severely affected. Bimanual move-

ments, such as clapping, were extremely diffi-
cult. The cranial nerves were normal as were the

ocular fundi. The motor examination showed

involuntary movements contrary to the

patient’s stated intent, but the types of move-

ment differ in the callosal form, there are pur-

posive movements of the non-dominant hand.10 In the lateral form, there is grasping and utilisation behaviour of the dominant hand.2 In the corticobasal degerination, there are aimless movements of either hand.1

When a consequence of parasitogenous 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 (es-

pecially 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 resembles those reported by Riley et al in corticobasal degeneration. These authors described the alien limb as “ involuntarily raising 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 “didn’t”. 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 present-

ing with an alien hand with or without myo-

clonus.

We are indebted to Professor Eran Zarelli, Depart-

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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 Gastro-

enterology and Nutrition (ESPGAN) criter-

ia. Since then she was on a strict gluten free diet and was asymptomatic until the age of 10 years when severe diarrhoea, 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 weak-

ness 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. Neurolog-

ical examination disclosed symmetric, pre-

dominantly distal, weakness of the legs; the knee jerks and ankle reflexes were depressed; plantar reflexes were flexor. Distal stock ing glove decreased 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: hemogram, erythrocyte sedi-

mentation rate, serum urea, creatinine, elec-

trolytes, creatinine, glucose, transaminase, bilirubin, immunoglobulins (Igs), lead, iron, copper, urinary analusis, urinary porphyrin, folic acid, and vitamins A, B1, B6, B12, and E. Anti-

tibodies to Coxsackie B virus were negative, as were antibodies to enterovirus antibodies, specific and non-specific organautoantibodies, IgA and IgG antilida-

min antibodies (AGAs), IgA antidiendosperm antibodies (EMAs), and IgA antireticulceil antibody (ARA), assayed by enzyme linked immunosorbant assay (ELISA) and immu-

nofluorescence (IF) were also negative. Lumbar puncture was not performed. Anti-

bodies against gangliosides GM1 and GD1b, myelin associated glycoprotein and myelin
Electrophysiological study suggestive in both episodes of an acute demyelinating peripheral neuropathy confined to the lower limbs. Values were within normal limits as the upper limbs.

<table>
<thead>
<tr>
<th>1st Episode</th>
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<tr>
<td>Precordial</td>
<td>Tibial</td>
</tr>
<tr>
<td>MCV (ms)</td>
<td>26</td>
</tr>
<tr>
<td>DL (ms)</td>
<td>74</td>
</tr>
<tr>
<td>F wave latency (ms)</td>
<td>70</td>
</tr>
<tr>
<td>CMAP (µV)</td>
<td>3</td>
</tr>
<tr>
<td>SCV (ms)</td>
<td>Sural</td>
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<tr>
<td>AMP (µV)</td>
<td>16.2</td>
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</table>

Basic protein were not tested. Nerve conduction studies were consistent with a predominately motor demyelinating peripheral neuropathy (table). Her symptoms improved spontaneously and she was discharged home after 2 weeks. For 2 years she was asymptomatic 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 gastrointestinal 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 including burning paraesthesia. On neurological examination the legs showed marked diminution in muscle power; absent deep tendon reflexes, and a reduction in pain and temperature; light touch, perception of position, 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/mm$^3$. Laboratory investigations were within normal values as in the past. IgA and IgG AGA, IgA EMA, and IgA ARA assayed by ELISA and IF were again negative. Nerve conduction studies confirmed the presence of a predominantly motor demyelinating neuropathy (table). The parents refused consent for a lumbar puncture or nerve biopsy.

Over the next 2 weeks her neurological disabilities 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 common 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, experienced 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, occurring within weeks.

The present case, however, differs clinically from those with neurological involvement previously reported. In the paediatric age group, in fact, neurological complications of celiac disease are rarely encountered and are mostly confined to the CNS; to the best of our knowledge, there are only two previously reported cases of PNS involvement in children with celiac disease. In both cases, however, these chronic axonal polyneuropathies presenting during a gluten free diet.

In both episodes in the present case neurophysiology was strongly supportive of a demyelinating peripheral neuropathy, which is most commonly attributed to a direct immunemediated attack to the myelin. By contrast, wallerian and axonal degeneration may be caused by vasculitis, and nutritional, metabolic, and toxic factors.

An autoimmune pathogenesis in association with strong evidence of a genetic susceptibility has been proposed for celiac disease. Although it is well established that AGA, EMA, and ARA are reliable indicators of sensitisation to gluten at least at the time of diagnosis, in the clinical practice at follow up, during a gluten challenge, pathological values of these antibodies may not be detected. In the present case the time course of the disease might be suggestive of an antibody mediated response. However, we could not detect pathological concentrations of AGA, EMA, or ARA antibodies either during the course of the disease or at follow up.

It is known that in celiac disease many immunological perturbations can occur outside the gastrointestinal tract. Crossing of the antigens through a damaged small intestinal mucosa, deposition of immune complexes in target organs, a reduction in immune surveillance, mechanism of molecular mimicry, and activated T cell response may contribute to the pathogenesis of the diseases associated with celiac disease. Direct toxic effects of gluten and vitamin deficiency are other possible pathogenic mechanisms of damage to the nervous system. Although we ruled out a vitamin deficiency it is still questionable whether a toxic neuropathy can be the case.

In conclusion, the present case shows two major issues: an acute polyneuropathy can be a complication of celiac disease in childhood and its benign course could help in the understanding of the underlying pathogenic mechanisms.

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Frontal release signs in older people with peripheral vascular disease

A growing body of research examining neurological aspects of clinically “silent” cerebrovascular disease suggests that neurological signs indicative of generalised organic brain damage may occur in the absence of completed stroke. These soft signs include primitive reflexes (frontal release signs), representing an anatomical and functional deafferentation of cortical from sub cortical structures. Primitive reflexes are known to occur in a wide variety of dementias, including Alzheimer’s disease and vascular dementia.

It is likely that the presence of undetected cerebrovascular disease accompanying peripheral vascular disease is underestimated, as peripheral vascular disease is known to be a risk factor for transient ischaemic attacks. A study assessing 373 older patients with peripheral vascular disease found that 72 of the 144 patients who had not experienced a transient ischaemic attack or stroke were found to have a degree of carotid stenosis of between 60% and 99%.

In the present study, the prevalence of primitive reflexes was examined in a large sample of community residents from the catchment area of an inner city London teaching hospital.

Twenty five consecutive non-amputees on the waiting list for femoropopliteal bypass operation were compared with 25 postoperative patients who had undergone elective hip or knee replacement and a period of inpatient rehabilitation. All participants were aged 65 and over at the time of interview. Patients with peripheral vascular disease all had clinical and Doppler proved evidence of peripheral ischaemia. Controls were interviewed between 6 months and 1 year after their operation. Both groups had no history of stroke or transient ischaemic attack.

A more detailed description of instruments is provided elsewhere. All subjects were
examined using a rating scale for the examination of frontal release signs (FRSS), with nine operationally defined items, each on a seven point semi-quantitative scale. The nine reflexes were paratonia and palomental, 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 test) and generalised cognitive impairment (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 subscales 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. All patients were examined for evidence of peripheral vascular disease. A comparison of the hand/foot grasp reflex, the glabellar reflex, the rooting reflex, the palpmontal reflex, and the sucking reflex (visual/tactile) was made (table). Only subscales were compared between groups.

Table 1 Primitive reflexes in patients with peripheral vascular disease (n=25) and controls (n=25)

<table>
<thead>
<tr>
<th>Hand grasp</th>
<th>Foot grasp</th>
<th>Glabellar</th>
<th>Palomontal</th>
<th>Paratonia</th>
<th>Rooting</th>
<th>Snout</th>
<th>Sucking (tactile)</th>
<th>Sucking (visual)</th>
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<tr>
<td>pValue</td>
<td>0.15</td>
<td>1.0</td>
<td>0.001*</td>
<td>0.15</td>
<td>0.29</td>
<td>0.01*</td>
<td>0.44</td>
<td>0.08</td>
</tr>
</tbody>
</table>

*pHigher 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 a prominent 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 Mr 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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Factitious 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 an ex-smoker 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 pseudoaneurysm that had to be related to dye injection, and phenytin 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 phenytin 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 hemiparesis to confrontation testing but was otherwise normal, including bilaterally symmetric optokinetic nystagmus. Motor examination showed paralysis 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, plasma glucose, plasma triglycerides, platelet count, and routine haematological and biochemical analyses were normal. A lipid profile showed mild hyperlipidaemia with increased low density lipoprotein-cholesterol. A computed tomography scan of the skull revealed a hyperdense left frontal lobe abscess, measuring 1.5 cm x 1.0 cm x 1.0 cm, with associated mass effect. The patient was started on intravenous ceftriaxone and clindamycin and underwent neurosurgical intervention with evacuation of the abscess. The patient’s condition improved steadily over the next few weeks and he was discharged to a rehabilitation unit on the fifth post-operative day with complete resolution of the left hemiparesis.
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 mmol/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 calculation and spelling errors, the second involving unusual “near miss” letter substitutions or reversals (for example, “anixety”, “execu- tion” and spelling errors, the second involving memory, as well as several atypical calcula-
tive, 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.1 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 symp-tomatology just as he was scheduled for return to work after his first non-organic hemiplegic episode, and the intentionality required to feign poor clock drawing and constructional apraxia, there is much to sup-
port a diagnosis of malingering.1 Nevertheless, classification as a factitious dis-
order is at least as justifiable in view of the patient’s willingness to undergo medical investigations, including video monitoring.

It is unclear how or when the patient acquired the information needed to mimic a constructional apraxia. Previous bedside neuropsychological evaluations may have served to familiarise him with the format of such testing, acting as an impetus to research the issue of stroke and focal brain deficits (which might also have occurred after his father’s stroke), much in the same way he is now researching conversion disorder, thereby discovering what expected answers should look like. Despite repeated questioning, how-
ever, no evidence could be gathered from the patient to support this speculation.

2 Frigato G, Amin K. Digit memory test: unequivocal cerebral dysfunction and sus-

Anosognosia and mania associated with right thalamic haemorrhage

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

A 53 year old, right handed, black man, with a history of alcohol misuse and depend-
ence 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 “bellig-

erent,” “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, mid-sited, hyperacute thalamic bleed with mass effect and oedema. The patient was extu-
bated 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 contralateral gaze palsy, supranuclear vertical gaze palsy, difficulty converging, left sided hemiparesis, and dense, left sided hemianesthesia. Deep tendon reflexes were absent on the left and Babinski's reflex was 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 more confused to the nurses’ question 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, but he was not accustomed to seeing it 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 after stroke, the patient more consistently acknowledged that he was weak on the left side of his body. A request for disabled housing “so that I won’t be a burden to my family” seemed to indicate an appreciation of his impotence. The patient was sleeping, within an hour of making such statements the patient might insist that after a week’s exercise he would be ready to return to work. His awareness of his hemiplegia fluctuated for 8 weeks after the 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 extravagantly the hospital food, and the nurses found him “talkative.” He re-iterated Cutting’s statement that after a short time “so that I won’t be a burden to my family” and boasted of having fathered 64 children. If the patient was less than completely “euphoric” and manic, he scored within the range. The mania resolved and he had a good appetite. When beginning to double simultaneous stimulation, but, although he could see to the left, was still missing targets in his left visual hemifield. Visual integration, both with and without the requirement of construction, was severely impaired. He was able to correctly recognise and produce facial emotional information. Simple attention was intact, but attentional control (backward span and mental control) was impaired. Visuomotor tracking was slow and he had significant problems with conceptual shifting and perseveration (visual). Later, tracking difficult processes included very poor reading ability, impaired confrontation naming, and impaired performance on a verbal task of fluency and initiation. Auditory comprehension was mildly impaired. Vocabulary scored formally in the borderline impaired range, as did abstract verbal reasoning. On tests of praxis he demonstrated a tendency to use the hand as object. Memory performance was intact. His initial recall of two paragraphs scored formally within the low average range and after a 30 minute delay, he was able to recall most of the information initially encoded, scoring formally within the average range.

Structural brain MRI on admission to the emergency room showed a large right thalamic haemorrhage with mass effect and oedema, with oedema extending into the cerebral peduncle and showing susceptibility consistent with deoxyhaemoglobin. Also present was increased T2 signal bilaterally in frontal areas consistent with ischaemic changes. Brain CT 30 days after stroke showed, in addition to the thalamic lesion, moderate cerebellar atrophy and mild to moderate prominence of the frontal cortical sulci compatible with cerebellar atrophy. Structural MRI performed 44 days after the stroke showed right thalamic haematomata. Functional MRI performed the same day demonstrated a 2 cm area of absent cerebral blood volume at the posterior margin of the right thalamus without any evidence of decreased cerebral blood volume within the right parietal, frontal, or temporal cortex.

This is a case of anosognosia of hemiplegia and mania co-occurring in a patient with a large right thalamic haemorrhage. Although anosognosia and mania are not generally thought of as occurring together, when Babinski’s introduced the term anosognosia he used it as one of his examples. In a case in which the patient, though convinced, was “a little overexcited,” and in a later paper he presented a case in which there was “a certain agitation, which expresses itself by exaggeratedлогичность, a decrease in attention, and a tendency to erotic ideas.”

Weinstein and Kahn noted that euphoria was common in patients with anosognosia. Moreover, although Cutting emphasised that apathy is the mood more usually associated with anosognosia, 10% of his patients with anosognosia were described as having “euphoric mood.”

Right sided thalamic lesions are known to produce both anosognosia and mania, but the relation of each to the pathology is unclear. Only some of the patients with right hemispheric lesions are manic or agnostic. These two syndromes may be related to dysfunction of different neural networks and only occur together when a disease process affects both networks.

Another possibility is that these syndromes are aetiologically related. Could anosognosia be a manifestation of mania? Although it is easy to conceive how elevated mood might facilitate anosognosia of hemiplegia (or other types of anosognosia), it is difficult to explain the presence of denial in ownership and dislike of the left arm (other anosognic phenomena) on the basis of euphoria. Moreover, Starkstein et al., finding that similar frequencies and severities of major and minor depression were present in patients with and without anosognosia, suggest that a particular mood state may not necessarily influence anosognosia.

Several explanations have been proposed to explain the phenomenon of anosognosia. The models invoke dysfunction of the cerebral cortex, especially the parietal cortices, or is interesting that in this case functional MRI failed to demonstrate decreased CBV in the parietal lobe. In summary, we present a case of anosognosia accompanying mania and post-thalamic haemorrhage. The coexistence of mania and anosognosia may be more common than previously appreciated. The association 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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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 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 epileptic seizures have been recognised for more than 90 years. They provoke diagnostic confusion and may be a mechanism of sudden unexplained death in epilepsy. Wherein 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 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...
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 disoriented immediately before a collapse. During the period of unconsciousness he would demonstrate no involuntary movements, orfacial automatisms, or cyanosis but he would become pale and “ashen” while staring straight ahead with a glazed look. Recovery of the episode his four 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 hypoxic 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 trace spikes were seen over the right frontotemporal region during sleep. The onset of the episode was not witnessed and the patient was found lying on the floor, regaining consciousness at about 07:06. The event EEG showed a short run of bilateral semirhythmic 2–3 Hz activity at 07:04:34 (figure A), persisting for 8 seconds before being obscured by muscle and movement artefact. Twenty four seconds later the ictal EEG, change, at 07:04:58, the ECG changed from sinus rhythm at 90 bpm to a brief period of sinus bradycardia, followed by a period of asystole with only very occasional ventricular complexes lasting 10 seconds (figure B). After a few seconds of bradycardia then tachycardia, sinus rhythm was restored. Throughout the episode the QT interval on the ECG remained within normal limits. The EEG became visible for 16 seconds into the asystolic period, at which time it was dominated by diffuse low amplitude slow activity at <1–2 Hz which persisted for 10 seconds (figure C). This was followed by marked attenuation of the EEG activity over the next 10 seconds before large amplitude generalised rhythmic <1Hz activity became apparent. Diffuse theta activity was seen for a further 15 seconds before the EEG return to its resting state.

A VVI permanent pacemaker was inserted. The phenytoin was withdrawn and replaced by lamotrigine. Carbamazepine was left unchanged. The patient was discharged, his colour and consciousness at about 07:06. The event EEG using an Oxford Instruments digital EEG receiver was performed continuously for 8 seconds before being obscured by muscle and movement artefact.

It has been hypothesised that there is later- alisation with respect to central autonomic cardiac control with an increase in heart rate seen after an increase in injection of amobarbital and inactivation of the left hemisphere and a decrease in heart rate on right hemispheric inactivation. Experimental stimulation of the rostral posterior insular cortex in anaesthetised rats has been shown to induce tachycardia and more caudal region stimulation to cause bradycardia. The prolonged stimulation resulted in ventricular ectopics, heart block, QT prolongation, and death. In percutaneous temporal lobectomy patients stimulation of the left insular cortex (particularly posteriorly) produced bradycardia and a depressor response significantly more often than tachycardia and a pressor effect. It was suggested that an epileptic discharge in the insular cortex may result in cardiac arrhythmias.

Recurrent episodes of loss of consciousness are a common clinical feature. An accurate diagnosis relies principally on the patient’s and witnesses’ accounts of events. Further investigations are frequently required which are often normal unless an episode is captured directly on EEG. Recording solely the EEG or the ECG may result in erroneous conclusions being drawn and insufficient or inappropriate therapy being instituted. Distinction between a primary cardiac arrhythmia and a secondary central arrhythmia is possible only with simultaneous EEG/ECG recordings.

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

Hereditary neuropathy with liability to pressure palsies (HNPP) is an autosomal dominant 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 entrapment sites. Respiratory muscle weakness has not been previously reported in HNPP. We describe a patient with HNPP who developed respiratory failure and proximal muscle weakness that was 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 Honour Red Cross Hospital with a history of a cardiac event with a coma due to CO, narco-sis (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 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 and slower 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. His position sense was normal. His vital capacity was 1.9 l (55% of the normal mean) in the sitting position, but 1.3 l (38%) in the supine position. The percentage of forced expiratory volume in 1 second was normal (99%) and the forced inspiratory capacity at inspiration and expiration showed poor movement of the diaphragm but no abnormality in the lung field. Routine haematological and serological studies gave normal results. No monoclonal or polyclonal proteins were detected. IgG and IgM antibodies to gangliosides GM1 and GD1b were negative. Analysis of CSF showed 1 lymphocyte/mm3 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 (52%, normal>55%), ulnar (54 ms [normal>45]), 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 cuneibulbar tubal 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

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delayed (8.7 ms (normal<8.0)). Sensory nerve conduction studies showed a reduced amplitude of sensory nerve action potentials and conduction slowing in all the nerves tested. Electromyography carried out in the supraspinatus, deltoid, biceps, flexor carpi ulnaris, brachioradialis, quadriceps femoris, biceps femoris, tibialis anterior, and gastrocnemius muscles showed polyphasic motor unit potentials of long duration, but denervation potentials were rare. A left sural nerve biopsy showed scattered tomaculous thickening of the myelin sheath and some abnormally 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 condition 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 entrainment sites, suggesting demyelinating neuropathy.

Our patient recalled experiencing recurrent episodes of transit entrapment mononeuropathy, 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. Although 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 experienced hypventilation in the supine posture and paradoxical movement of the abdomen, which suggested diaphragmatic weakness. Also, chest radiography showed poor movement of the diaphragm. Although the prolongation of distal latency in the phrenic nerve was mild considering the severity of respiratory 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.

Diffuse proximal weakness in our patient is an uncommon finding as for HNPP. Mancardi et al. reported on three patients with progressive 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 respiratory function in HNPP.

We thank Dr T Yamamoto from the University of Occupational and Environmental Health for the gene analysis and Ms T Nagase from Chiba University for his technical help with the sural nerve biopsy.
venous thrombosis is often asymptomatic, or presents with non-specific pain, it is probably unrecognized in many cases.1 Concurrent ipsilateral spinal accessory neuropathy and internal jugular venous thrombosis after CEA is expected to be rare, and this is underscored by the 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. The symptoms persisted, and 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 spinal accessory 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.

Spinal accessory neuropathy was previously first reported as a complication of CEA in 1982. Since then, there have been several case reports and small series.1 A 1996 review of reports of cranial neuropathy after CEA disclosed only one patient with spinal accessory neuropathy in over 3000 cases.1 Although the authors did not include several other reports2–4 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. More frequent spinal accessory neuropathy after CEA may be more frequent. The cause of spinal accessory neuropathy after CEA is usually not well established, but intraprocedural nerve stretching or compression from retraction is most often invoked.5 Delayed onset (after 3 weeks) has been noted in some; for these patients, postoperative inflammation and scarring seem more likely causes. Spinal accessory nerve transection or ischemia/infarction (arterial or venous) are other possibilities. As in our patient, high carotid dissection and retraction have been reported to precede spinal accessory neuropathy.1,4

The spinal accessory nerve courses along the internal jugular vein and near the internal carotid artery, typically well above the carotid bifurcation. It is thought that a high incision and retraction resulting from a high carotid bifurcation would place the nerve at risk. Whether this realisation may lead to any technical modification to decrease the risk of spinal accessory neuropathy in those with a high bifurcation remains to be determined.

From our search, internal jugular venous thrombosis after CEA has been reported in only one case.2 As Southcott et al noted, retraction of the internal jugular during CEA may cause stasis, which may lead to thrombosis from venous stasis or endothelial injury. Other causes of internal jugular venous thrombosis include jugular cannulation, blunt cervical trauma, and a hypercoagulable state. Internal jugular venous thrombosis may occur at any stage after neck dissection, often with recanalisation after several months.3

The presence of induration about the incision site and a palpable supraclavicular cord in our patient led us to suspect venous thrombosis. The delayed onset of spinal accessory neuropathy, leading to thrombosis from venous stasis or endothelial injury. Other causes of internal jugular venous thrombosis include jugular cannulation, blunt cervical trauma, and a hypercoagulable state. Internal jugular venous thrombosis may occur within a week after neck dissection, often with recanalisation after several months.3

Common pathogenetic mechanisms for spinal accessory neuropathy and internal jugular venous thrombosis may include intraoperative traction, haematoma, and postoperative inflammation. 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 the 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.

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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 alert the sports community to possible serious adverse effects of energy supplements.

A 33 year old man had a severe aphasia 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 cervical angiography were normal. Cerebral CSF examination revealed a normal protein and no cells.

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 creatinine 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 performed a transatlantic air flight, there was no deep venous thrombosis and D-dimers were normal. However, ephedrine has an indirect sympathomimetic action by virtue of its role first for arteriolar vasodilatation in addition to other catecholaminergic effects. Both ischaemic and haemorrhagic stroke associated with ephedrine use have been reported.1 Acute myocardial infarction and acute psychosis have also been reported after taking ephedrine and other sympathomimetic drugs.2 Ephedrine and its metabolites are natural products that are used in non-prescription medicines for multiple uses, including weight loss and body building. 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 creatine monohydrate daily for about 6 weeks before his stroke.

Acute myocardial infarction and acute psychosis have also been reported after taking ephedrine and other sympathomimetic drugs.1 Ephedrine and its metabolites are natural products that are used in non-prescription medicines for multiple uses, including weight loss and body building. 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 creatine monohydrate daily for about 6 weeks before his stroke.

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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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Petroclival meningioma as a cause of ipsilateral cervicofacial dyskinesias

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...
decreased on the left side. Furthermore, there was mild left dysdokinesia. Neurography of the facial nerve was normal on both sides. Needle myography of the left frontalis and orbiculari oculi did not show signs of denervation.

An MRI study showed a large gadolinium enhancing tumour within the left cerebellopontine angle extending to the cava Beck with marked displacement of the brainstem to the contralateral side (figure A and B). Digital subtraction angiography showed a discrete blush of the tumour as typically seen in meningiomas. 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 hypoesthesia. Audiometry remained unchanged. 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 dyskinesias occurred during the next weeks.

The postoperative improvement of the dystonic and choreic grimacing and the cervical dystonia indicates a causal association between the petroclival meningioma and the segmental hyperkinetic movement disorders. Such a relation is supported also by the absence of a family 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 posterior fossa have been reported only rarely. Asymptomatic blepharospasm was recently found in a patient with an ipsilateral mesencephalic cyst.6 Hemifacial spasm was seen in patients with dystonic neurinomas, meningiomas, and epidermoid tumours of the cerebellopontine angle.7 Acoustic neurinomas and anaplastic pontocerebellar glioma can be associated with facial myokymia and spas tic parietic facial contracture.8 Also, cervical dystonia due to tumours of the cerebellopontine angle have been reported recently.9

The pathophysiological mechanisms responsible 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 previously.10 Alternatively, enhanced excitability of brainstem interneurons in cranial dystonia indicates a causal association between the brainstem interneurons in cranial dystonia and spastic muscular torticollis. Mov Disord 1988;3:61–9.

Acute multifocal cerebral white matter lesions during transfer factor therapy

Transfer factor is an active substance of unknown structure present in dialysable leukocyte extract which is assumed to transfer cell mediated immunity in an antigen specific fashion.2 The mechanisms of action of transfer factor are still far from clear; in vitro dialysable leukocyte extract increases macrophage activation and interleukin (IL) 1 production and enhances leucocyte chemotaxis and natural killer function. Transfer factor has been reported to stimulate the cell mediated antigen specific response in patients with various infections11; therefore, treatment with transfer factor has been suggested in patients with selective deficits in cell mediated immunity such as in some refractory neoplasms and chronic infections. Moreover, it has been used in the treatment of uveitis.7 Administration of dialysable leukocyte extract has seemed to be free of hypersensitivity, long lasting side effects, or complications, except for transitory hyperpyrexia.12

We report on a patient in whom multiple cerebral white matter lesions developed after taking dialysable leucocyte extract orally for uveitis. A 28 year old man was admitted to hospital because of headache, mental confusion, and right hemiparesis. He had had recurrent bilateral uveitis from the age of 12 to 14 with relapse in the right eye. In January 1995 retinal vasculitis was diagnosed at fundoscopy and in July 1995 he started oral transfer factor as dialysable leucocyte extract twice a week. He complained of generalised 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 6.0–9.0 g/l), although the serum protein fraction was normal, antistreptolysin titres (355 UI/ml, normal <200 UI/ml), and anticardiolipin IgG (30 UI/ml, normal 4–12 UI/ml). Negative results were obtained for HIV IgG and IgM and antinuclear, antineutrophil cytoplasmatic, anti-DNA, antithrombocytopenic, anti-ENA, anti-smooth muscle, and antineutrophil cytoplasmatic antibodies, lupus anticoagulants, cryoglobulins, immune complexes, complement fractions, and neoplastic markers.

Serological investigations showed IgG but not IgM against cytomegalovirus (CMV), Herpes simplex, Varicella zoster, Epstein-Barr virus, Coxsackie, Adenovirus, Enterovirus or Borellia burgdorferi were present. Polymeras chain reaction search for Herpes simplex 1 and 2, Varicella zoster, CMV, Epstein- Barr virus, and JC virus in the CSF was negative.

Cell, protein, and glucose concentrations in CSF were normal. No oligoclonal bands or antibody against CMV, Herpes simplex, Varicella zoster, Epstein-Barr virus, Coxsackie, Adenovirus, Enterovirus or Borellia burgdorferi were present. The close temporal relation between assumption of dialysable leucocyte 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 casual. Despite the absence of biopsy, we reasonably excluded

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the diagnosis of vasculitis or neuro-Behçet’s disease although in the absence of biopsy. In fact, the clinical, laboratory, and MRI findings were not typical and a low titre of anticitrullinated peptide antibodies is found in 2% of healthy subjects.1

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 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.2 In addition, CSF without oligoclonal banding argues against a diagnosis of multiple sclerosis, whereas it is commonly found in acute disseminated encephalitis.2 On the other hand the possibility that acute disseminated encephalitis may recur has been accepted3 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 autoantigen reactivity is only temporary 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.2 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 infections1 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 Depopovera 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 impairment 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 (WAIS-C=85 at the age of 13; Barbeau-Pinar=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 increased activity in basal ganglia relative to the cerebral cortex. A fine banded karyotype was normal. Serum calcium was 1.55 mEq/l (normal 2.15–2.55 mEq/l), phosphate 1.69 mM/l (normal 0.70–1.34 mM/l; urinary calcium was 0.8 mM/l (normal 2.5–6.3 mM/l). Serum parathyroid hormone was below 0.6 pmol/l (normal 1.19–1.34 µM/l); urinary calcium showed an absence (normal 1.0–6.55 µM/l), and a nuclear scan 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 behaviour 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. Although the tempo-ocular region is the most often involved in pervasive developmental disorders abnormal functioning of the frontal-temporal-parietal cortex is suggested by 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. Fahr’s disease consists of symmetric calcifications, located mainly in the basal forebrain and cerebellum, which are of various aetiologies. Cognitive and behavioural abnormalities may be present when calcifications occur early in development. A fortuitous association between pervasive developmental disorder and hypocalcaemia, 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 is 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 that are 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?

Hypertrophic atlantoaxial ligaments: an unusual cause of compression of the upper spinal cord

The craniovertebral junction can be affected by several pseudotumorous masses extradural located, such as rheumatoid panus, hypertrophic non-union of odontoid fracture, post-traumatic cicatrix, synovial cysts, tumorous calcium pyrophosphate dihydrate crystal deposition, tophaceous gout, calcification of the posterior longitudinal ligament, synovial disease-like pigmented villonodular synovitis, and synovial chondromatosis. Hypertrophy of the atlantoaxial ligaments as a consequence of degenerative disease was recently recognised as an individual entity. Only five previous cases have been published. We add another case to the short series available in the literature, emphasising that as a consequence of the spinal cord compression is amenable to surgical removal, symptomatic patients should be diagnosed and treated without delay.

A 66 year old woman presented with a rapid development of progressive spastic tetraparesis and an unremarkable medical history. There was no oedolysis or instability on plain cervical radiography and C.T. A bone scan with 'Tc was unremarkable. Magnetic resonance imaging showed a retro-odontoid extradural mass that was homogeneous and isointense on T1 weighted signal, demarcated no enhancement after intravenous gadolinium contrast, and was compressing the upper cervical spinal cord (figure). The laboratory tests were normal, confirming the absence of rheumatoid arthritis, metabolic disease, or gout. Surgical removal via a transtoral approach with a minimal bony resection was direct and provided sufficient space to obtain spinal cord decompression. It was followed by a posterior C1–C2 fusion. Macroscopically, the lesion had no capsule and resembled a hypertrophic ligamentum flavum. Microscopically, it was non-inflammatory, hypocellular, and ligamentary pieces found within the mass appeared fibrous and almost disintegrated. The patient regained normal neurological function. Over a 3 year follow up period there was no recurrence.

We focus attention on hypertrophic atlantoaxial ligamentary disease as a degenerative disease that must be considered within the possible causes of high spinal cord compression.

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Selective hemihypesthesia 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 reflex, were normal. The patient’s only complaints were left temporal headache and right hemihypesthesia.

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 high intensity. (figure). The lesion shown in our MR images appeared 6 months 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 craniocevicular 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 MR images in our case showed a discrete 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.

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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-aminobutyric 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.1 Degeneration of certain cerebellar pathways is probably responsible for the loss of this dopaminergic innervation.2 Dopamine agonists could therefore be of potential interest in the treatment of toluene induced tremor. This hypothesis was explored in a recently described case,3 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 nigrae 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 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 local ablation of these neurotransmitters in the CSF of patients with heredodegenerative ataxias.4 In our patient, amantadine hydrochloride (100 mg twice daily) abolished postural tremor and ataxia completely over a 3 month period. Subsequently, the treatment was discontinued, which resulted in relapse of the tremor and ataxia. He was challenged to amantadine, which progressively offered him the same clinical improvement as in the first 3 months. After 3 years the treatment was discontinued without any sign of relapse.

Although this finding needs confirmation, amantadine treatment could form a new approach in the medical treatment for toluene induced tremor and ataxia. Intractable cases would then justify a more aggressive approach such as ventointermedius thalamotomy.

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

Nabout 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 children with tuberous sclerosis complex be understood well.

We think that there are two problems with this study that should make the physician cautious about the risk factors identified by Nabout et al. as a basis for a screening programme. The first is that this study was performed 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 point 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 Monro. 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. A 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 Monro”. Inclusion criteria for one study 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 which subependymal lesions will become invasive is important. As subependymal nodules and SEGAs seem to be histologically identical it is unlikely that pathologists will be able to provide an answer. The study of Nabout et al. suggests some new hypotheses which perhaps allows 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 amyotrophic 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, Katz et al. described a series of patients affected by ALS that predominantly showed signs of lower motor neuron disease in the upper limbs, with severe proximal and varying degrees of distal involvement, calling it amyotrophic 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 neuromuscular
“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 scapulohumeral form, or the chronic anterior poliomyelitis reported by Vulpian in 1886 and known in Franco-German literature as Vulpian-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 scapulohumeral distribution (over 45 years of age) generally leads to ALS as a matter of course. 1

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 = 0.002). (2) The age of onset of this form was similar to the rest of ALS. (3) There was a higher percentage of men in this group (83.5% of men and 80.7% of women over the age of 55). The faster progressive deterioration of the disease’s clinical course, in that they usually preserve their ability to walk for several months in the ALS group). (4) Survival of 57 months compared with 39 months in 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 = 0.002). (2) The age of onset of this form was similar to the rest of ALS. (3) There was a higher percentage of men in this group (83.5% of men and 80.7% of women over the age of 55). (4) Survival of 57 months compared with 39 months in 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.

Sasaki et al reported four important statistical discoveries in this form of ALS: the prevalence percentage of 10% of the whole ALS group, the similar age onset to the rest of ALS, a predominance among men (the male/female ratio was 4:1 in our study), and a longer median survival. It is clinically important to give wider publicity to the existence of this atypical form of ALS to avoid unnecessary surgical intervention for cervical abnormalities.

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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 transcranial magnetic stimulation induced absent or delayed corticoluminal responses at the tongue, the authors ascribed isolated dysarthria to interruption of the corticobulbar pathways. On the whole, 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. 1 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-pharyngeal-glosso-mandibular apraxia (anterolateral 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 language areas, resulting in dysfunction of these cortices. 1 Therefore, we postulated that isolated dysarthria results from interruption of corticobulbar networks indispensable for speech output, involving the thalamocortical and corticostriatal 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. The authors concluded 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 paresis was 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 incoordination of multiple organs necessary for speech articulation as well as a dysfunction of the corticobulbar system. Although interruption of the corticobulbar 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.


Sasaki et al. We thank Gamez et al for their interest in our article concerning the atypical form of amyotrophic lateral sclerosis.1

Over many years, several researchers have recognised this peculiar distribution of muscle atrophy in clinical practice. The clinical manifestations consist of the muscular atrophy confined to the chest girdle and the arms (proximally dominant), absence of deep tendon reflex in the arms, almost normal deep tendon reflex in the legs, and subluxation of the shoulder joints. Some patients progress to bulbar involvement. As Gamez et al cite, many terms have been coined to describe this peculiar pattern of the muscular atrophy such as dangling arm, orang utan sign, dead arm syndrome, amyotrophic brachial diplegia syndrome, and man-in-the-barrel syndrome. Some patients classified into a category of motor neuron disease (ALS) or spinal progressive muscular atrophy. However, others could not exclude the possible cause of cervical diseases such as associated motor loss in the upper extremity.2 In fact, these patients had cervical abnormalities such as cervical spondylosis: a distinctive variant of amyotrophic lateral sclerosis. Neurology 1999;63:851–5.


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Urban et al reply:

Okuda et al draw attention to their article on pure dysthria in Stroke which we read with much interest. They refer to 12 patients with pure dysthria, 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 that the single lesion collected by us was more appropriate to correlate lesion topography with impaired function. The findings of Okuda et al are in line with our conclusion that interruption of the corticofugal pathways is the pathogenesis of dysthria of extracerebellar origin. Obviously, impairment of the corticofugal tract of one hemisphere by a single small lesion is an adequate condition for dysthria. The patients of Okuda et al had more severe vascular disorder of the brain than our patients as can be concluded from the multiple infarctions. Thus, the bilateral cortical frontopetal hypoperfusion as disclosed by SPECT in the series of Okuda et al may be due to infarction in other parts of the brain compared with the lesion causing pure dysthria.

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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 the 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 are due to differences 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 correlation with a dysthria rating scale, had a more advanced stage of the disease possibly with coexisting dystonia or rigidity. These assertions deserve some comments.

The mean disease duration of our nine patients with Huntington's disease was 6.2 (4.1) years which is actually shorter than the duration of the six patients reported by Hanajima et al (8.3 (5.9) years). Most of our patients could be considered in an early stage of the disease, as the Unified Huntington's disease rating scale, and none presented dystonia, rigidity, or any other additional movement disorder. In this regard, it should be pointed out that bradykinesia is often associated with chorea in patients with Huntington's disease and may even precede the appearance of choreic dyskinesia. Chorea itself is often reduced in the more advanced Huntington's disease stage. It is unlikely, therefore, that any neurophysiological approach can test purely chorea even in the early Huntington's disease stages. In addition, different mechanisms are involved in Huntington's disease and other choreas as suggested by the lack of impairment of somatosensory evoked responses and long latency stretch reflexes in the second.

We were not really surprised at the results of Hanajima et al as we do share their opinion that patients with Huntington's disease may be characterised by large individual differences in the involvement of motor cortical areas. Actually, three patients in our study showed an amount of intracortical inhibition within the confidence limits of the control population. We also think that the impairment of intracortical inhibition is likely to develop during disease progression as we did not find any change in four patients, two of them already reported, with positive DNA testing but completely asymptomatic.

The discrepancies between the two studies are more likely to be explained, at least in part, by some methodological differences. For instance, the amplitude of the control response was larger in our series (approximately 1.0 mV compared with 0.3 mV in the study of Hanajima et al). This may induce a different sensitivity of the test, and the amount of intracortical inhibition in our normal control is greater (see also) than in the study of Hanajima et al.

When interpreting the results of studies with paired transcranial magnetic stimulation pathophysiologically it should be kept in mind that similar changes of intracortical inhibition have been shown in patients with various movement disorders (focal dystonia, myoclonus, parkinsonism, restless legs syndrome, Tourette's disorder), but also in Huntington's disease (stage of the disease, severity of the disease (stage of the disease) is one factor to judge the disease stage, the severity of the disease (stage of the disease) is also positively correlated with CAG repeat number.

We may have to take CAG repeat number into consideration in comparisons. Unfortunately, however, we have no way to do such comparisons between these two studies. We could say, at least, that the intracortical inhibition was normal even at the same stage of the disease as that of the patients of Abbruzzese et al, if studied with our method.

We also consider that methodological differences are very important in paired magnetic stimulation. The results strongly depend on the intensities of both a conditioning and a test stimulus. Especially, the intensity of the conditioning stimulus is critical. We have no difficulty in showing normal inhibition, but have much difficulty in showing reduced or absent inhibition because of such marked dependence of the results on the intensities of stimuli. Therefore, we used one intensity of the conditioning stimulus before we confirmed inhibition in studies of patients.

We used an intensity of 5% less than the active threshold as a conditioning stimulus to avoid false-positive results in the study of chorea. We did not need to change the intensity of the conditioning stimulus because we always obtained a normal inhibition with this intensity. We consider that this is very important. If using a suprathreshold (active threshold) conditioning stimulus, a facilitatory effect must often superimpose on the intracortical inhibition. This makes the interpretation difficult. Was the intensity of 80% of the resting threshold always below the active threshold in their patients? In our experience, 80% of the resting threshold was sometimes above the active threshold. These factors must be considered in interpreting the results of paired magnetic stimulation.

Such a methodological problem is inherent in human studies because we have no direct way of detecting the threshold of the motor cortex. Our two results must be true. We may have two completely different interpretations of these results. (1) The intracortical inhibition is normal in Huntington's disease. Abbruzzese et al showed the reduced inhibition because they used a high intensity conditioning stimulus with which the degree of the
intracortical inhibition is often decreased even in normal subjects. The 80% of the threshold for relaxed muscles must correspond to different values relative to the threshold for active muscles in patients that from 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 t is equal to arterial blood pressure at the given time (ABP(t)) minus CCP divided by cerebrovascular resistance (CVR):

FV(t) = (ABP(t)−CCP)/CVR (1)

At the time of systolic and diastolic pressure values (ABPs, ABPs), respectively, it follows that systolic and diastolic flow (FVs, FVs) should be equal to (ABPs−CCP)/CVR and (ABPs−CCP)/CVR, respectively. However, in patients with head injury, it is not true. In fact, it has been reported that the vascular resistance valid for the static pressure/flow relations (CVR0, concerning mean pressures and flows) is different from and in general much higher than resistances determining dynamic pressure/flow relations (CVR1) as in the case of pulsatile flow. 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; A1=amplitude of the pulsatile pressure wave; F1=amplitude of the pulsatile flow wave):

FV = (ABP−CCP)/CVR0 (2)
F1 = A1/CVR1 (3)

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

CCP2 = ABP−A1/F1 (4)

leads to

CCP2 = ABP−CVR1/CVR0×(ABP−CCP) = ABP−CVR1/CVR0×CVR1/CVR0 (5)

Obviously, 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 = 0.5ABP+0.5CCP (6)

With decreasing CVR1/CVR0 ratios, CCP2 becomes more and more dependent on ABP and independent of CCP. In any case, without exact knowledge of the CVR1/CVR0 ratio, equation 4 is useless for a valid CCP calculation.

The second criticism concerns the correlation of the calculated CCP values with ABP found by the authors (p<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 cerebral 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 vasocostriction. 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 = and FV(t) 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) rather than by ABP−CCP. Therefore, equation 2 changes to

FV = (ABP−ICP)/CVR0 (7)

and equation 5 to

CCP2 = ABP−(1/CVR0)×CVR1/ICP (8)

Equation 7 explains well the positive correlation 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”.1

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Czosnyka et al reply:

We thank Diehl very much for the interesting letter provoking some mathematical considerations about cerebral haemodynamics.

We need to emphasise that our primary intention2 was to investigate Burton’s hypothesis in patients with head injury of that critical closing pressure (CCP) may be represented by a sum of intracranial pressure (ICP) and the tension in the arterial walls.

CCP=ICP+active tension of arterial walls Aa1 proposed the mathematical formula taken for calculations:

CCP1 = ABP−ABPpp−FVpp×FVs (9)

(ABP and FV are mean values of arterial pressure and MCA flow velocity, ABPs and FVs are systolic values, ABPpp and FVpp are peak to peak amplitudes ).

A graphical interpretation of this formula has been given in figure 1. CCP1 is an x intercept point of linear regression between subsequent systolic and diastolic values recorded within 6 second intervals of flow velocity (along y axis) and arterial pressure (along x axis).

In fact, the formula proposed by Michel et al1 is very similar. The only difference is that instead of the original waveforms of FV and ABP, first (fundamental) harmonic components were taken for the same graphical construction—that is:

CCP2 = ABP−A1/F1×FV (10)

In our paper1 we confirmed empirically that both CCP1 and CCP2 produced the same values in a group of TBI patients after head injury, therefore the mathematical consideration of Diehl (equations 1–5) must contain an error! First of all we cannot see how equation (1) from Diehl’s letter can be derived from any of our formulae. Everyone has tried to plot momentary values from ABP pulse waveform against momentary values of FV waveform knows that it never plots a straight line (as equation (1) implies). We believe “clouds” of systolic and diastolic values of ABP and FV waveforms (fig 1 in1) one can rather see an ellipsoidal shape which is very seldom regular enough to be approximated by a straight section. Therefore, equation (1) in Diehl’s letter is not correct. In fact, CVR is a frequency dependent variable (represents vascular impedance) and if a linear theory can be applied, division in (1) should be substituted by a convolution with an inverse of Fourier transform of “cerebrovascular admittance”.

Definition of CVR0 as FV/(ABP−CCP) is completely artificial and lacks a physiological basis. It is rather taken from the geometrical interpretation of figure 1 in. In our material equivalent of parameter CVR0 (as defined by Diehl) is l.007 (SD 0.31) and CVR1 0.972 (SD 0.29), the difference between the two is not statistically significant. Therefore, the suggestion that the CVR0/CVR1 ratio is 0.5 is not correct. Real CVR0 should be calculated as (ABP−ICP)/FV. We fully agree that equation (5) proposed by Diehl is “useless for valid CCP calculation”—we have not used it and have never suggested anyone could do so.

The second criticism was that our CCP positively correlated with CCP1 and CCP2 might not be a surprise. When ABP decreases, vasodilatation occurs and arterial wall tension decreases. Therefore presuming CVR is constant, CCP should decrease. A rather weak (though significant) correlation suggests that not all of our patients were pressure reactive or ICP was not always constant.

The final issue concerning negative flow velocities is a trap Diehl has prepared for himself. We never suggested that any factor interpretable as cerebrovascular resistance (CVR0 or CVR1) should be involved in the concept of critical closing pressure. From the definition, closeness is a strongly non-linear phenomenon, therefore applying linear theory here is very
risks. How risky—we can see from Dziech’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 increased to infinity, only after death.

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 that procedure. Filling the thalamus from the globus pallidum internum are placed dorsocaudally to the subthalamic nucleus and could be blocked by high frequency stimulation. (3) When the recording electrode was placed medioventrally 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 seem to be present in the patient discussed here. Neuronal activity in the sensorimotor cortex of the subthalamic nucleus is different from the above but on occasions the distinction may not be easy. It is very 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 post-surgery MRI with measurements of the tip 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.


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

Reduction in the neuronal activity of the sub- thalamic nucleus leading to diminished exci- tation of the globus pallidum internum is associated with chorea-ballism in monkeys.1 Levodopa induced dyskinesias are currently thought to share a similar pathophysiology with chorea-ballism in monkeys.

Dyskinesias in Parkinson’s disease is higher than in intact animals. 7 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 substantia nigra. Enough cells are recorded along the tracks experimentally to suggest that changes in the background activity are likely to be identical at different points along the tracks.


behind the mean point of intercommisural a) posteroanterior: 1.5 mm of unquestionable benefit it is left in the surgery before cementing The evaluating electrode was placed in laterality 12. (range 17–98 Hz). Five cells responded to mentioned criteria) with a mean of 69 Hz of eight neurons were recognised as belonging to the subthalamic nucleus in the right hemisphere.

One track was performed. In the left hemisphere, two tracks were performed. One track was performed by the poor responding activity of the cells recorded. In the other track, nine neurons were recorded in the subthalamic nucleus (always following the above mentioned criteria) with a mean of 69 Hz (range 17–98 Hz). Five cells responded to passive and/or voluntary movements. One of them was also positive to tremor. The stimulating electrode was placed in laterality 12. The stimulating stimulating stimulating stimulating stimulating electrode is always tested in the surgery before cementing it and, only when the symptoms are considered of unquestionable benefit it is left in the chosen place. The final position of the electrodes, ascertained by ventriculography, was as follows: (a) posterointeranterior: 1.5 mm behind the mean point of intercommisural line, (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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Nitrin oxide in acute ischaemic stroke

The pivotal role of nitric oxide (NO) in cerebral ischaemia 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 ischaemic insult. One area not discussed in this editorial is the neuroprotective effect of 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors or “statins” in cerebral ischaemia. Preliminary studies have shown that statins modulate brain nitric oxide synthase (NOS) activity in a neuroprotective manner. Data from a murine model of ischaemic stroke demonstrate that prophylactic statin therapy reduces infarct size by about 30%, and improves neurological outcome in normocholesterolaemic animals. In this investigation, statin therapy directed to regulate endothelial NOS in the brain without altering expression of neuronal NOS. Lovastatin has been shown to inhibit cytokine mediated upregulation of inducible NOS and production of NO in rat astrocytes and macrophages, and this inhibition may represent a novel mechanism suppressing inflammatory responses that accompany ischaemia. Most interestingly, these preliminary findings suggest that statin therapy may modify the response of both the friendly and unfriendly faces of brain NO in a synergistically neuroprotective manner. These and other vascular effects of statins in cerebral ischaemia are potentially of great importance in human neuroprotection and ongoing is 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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BOOK REVIEWS


That neuroimmunology has come of age is demonstrated by the profusion of volumes published in the subject in recent years. This volume focuses on the central nervous system, and aims to satisfy the curiosity of both the clinician faced with a diagnostic conundrum and the experimental immunologist inquiring into the clinical relevance of his findings. At first sight it seems improbable that both of these goals might be achieved in one volume; this book however, succeeds admirably in what it sets out to do, as much as a result of its literary style as its content.

The intrusive authorial voice fell into disfavour in literary circles around the turn of the century because it was thought that calling 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 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 diseases 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 paraneoplastic disorders of the CNS, stiff man syndrome, neurologic complications of...

Organ transplantation, once medical exotica, is now almost routine. 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 Services, 1998). Organ basic surgical techniques were established at the beginning of the century in canine models. Translating these experiments to humans awaited safe and effective immunosuppression. Until recent times forms of immunosuppression were radiation (total body or total lymphoid) and non-selective chemical reagents (benzene and tolouene). Then the antiproliferative 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 1963 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 transduction (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 transplantation patients have a significant neurological complication that is not uncommon 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, perhaps the increasing success of organ transplantation serves mainly on improved immunosuppression with drugs that selectively suppress lymphocytes by inhibiting lymphokine generation (cyclosporin A, tacrolimus), renal transduction (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).

Instead the antiproliferative 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 1963 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 transduction (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).

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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 pragmatism. Roberts, in the most outstanding chapter, writes a lucid and well reasoned account of the need to search for and maintain narrative meaning in treating psychosis. This anti-heroic dehumanising effect to both patients and professionals of identifying individuals by their illness as in schizophrenics. Every psychiatric library should buy this book for this paper alone, which should be required reading for all psychiatric trainees. The rest of the book is of variable quality. There is a rather prosaic essay on gender for all psychiatric trainees. The chapters concerning attachment theory, a useful but over worked paradigm. However, there are two very fine accounts of narrative in psychotherapy by James Phillips and Jeremy Holmes. There are a few cavils. The section on antiepileptic drugs in pregnancy, (f) the need to consider the concept of pregnancy prevention well before the menopause (and not only with enzyme inducing drugs such as valproate has also been implicated), (g) discussion of differences (and available formulations) between synthetic and natural progesterone, (h) strand of pregnancy when various malformations are detectable on scanning, and (g) time to closure of the neural tube (different from the 21-sth thy they qualify as the “most sensitive time of the fetus to the induction of malformations by exogenous agents.”). Despite these comments (made with an eye on the next edition) I would recommend this book to all those involved in the care of women with epilepsy.

LINA NASHEEP


Childhood Epilepsies and Brain Development is the fruit of a symposium held in 1997 to try and bridge the chasm between those working in the clinic or at the bedside and those in the laboratory. Both groups must collaborate and communicate to improve the management of children (and their families) with epilepsy. 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 whole. The approach and section 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 very speculative insights into the pathogenesis of spasms. However, it was surprisingly severe myoclonic epilepsy of infancy did not merit a specific chapter in view of the unique electro-clinical evolution 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 cause and effect relation remains to be established. The chapters covering basic neurophysiology, neurochemistry, and neuropathology, are erudite and fascinating but at times are comprehensible. 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—for the benefit of the patient with epilepsy.

The concept of Childhood Epilepsies and Brain Development is innovative and commendable and although many 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. However, the book covers a long and long discussion on the effects of antiepileptic and anticonvulsant treatment in pregnancy, which is probably of the most concern to both clinicians and families. Many of the chapters are a very good account of the development will clearly be of particular interest to neurologists. However general psychiatrists wishing to improve their prescribing skills will find this book useful.

SIMON FLEMINGER


The Maudsley prescribing guidelines are produced each year for a local readership, but this, the fifth edition, is the first to go public. The authors and principal contributors, a mixture of physicians and psychiatrists with an interest and background in clinical psychopharmacology, are to be complimented on producing a guide of manageable size and ready accessibility. The book is divided into sections dealing with the treatment of broad groups of clinical disorders—for example, psychosis—special patient populations—for example, elderly people, with further sections on the management of emergencies and the adverse effects of psychotropic drugs. Much of the information is laid out in tabular form. It could become an indispensable resource for a busy on call psychiatrist or house officer (the dimensions would fit comfortably into the pocket of a clinical white coat, were they still to be worn) but more senior clinicians will find plenty of use for it in the clinic. It does not aim at great erudition, but provides a useful list of references. There are a few caviats. The section on treatment of anxiety is skimpy (one and a half pages) compared with say the treatment of affective illness (22 pages) or hallucinosis (19 pages). The brevity is only partly explained by the undeveloped state of that particular area of psychopharmacology. Sections on treatments for non-specific indications to and indications for lumbar puncture and indications for EEG seem to have been displaced from some other primer for busy junior doctors. There is no index. These quibbles apart, prescribing guidelines can be wholeheartedly recommended.

BRIAN TOONE
Toluene induced postural tremor

DIRK DELEU and YOLANDE HANSSENS

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