Rhabdomyolysis during interferon-\(\beta\)-1a treatment

Interferon-\(\beta\) (IFN-\(\beta\)) is one of the most effective currently available treatments for multiple sclerosis. It has also been used in the therapy of viral diseases and certain malignancies, as has the other type interferon IFN-\(\alpha\). Most frequent side effects are transient flu-like symptoms such as myalgia, chills, and headaches. We describe a patient with rhabdomyolysis who developed acute rhabdomyolysis during IFN-\(\beta\)-1a treatment. After the medication was discontinued, the patient improved rapidly.

A 39 year old man with a history of first symptoms in April 2000 was diagnosed as having rhabdomyolysis, supported by the demonstration of oligoclonal IgG bands in the CSF but not in the blood, and multiple white matter lesions in periventricular localisations on MRI. Treatment with 22 \(\mu\)g IFN-\(\beta\)-1a (Rebif\(\beta\), Serono, Unterschleissheim, Germany) by subcutaneous injection three times weekly was initiated in October 2000 after three exacerbations with predominant sensory disturbances leading to an expanded disability status score (EDSS) of 1.5. To alleviate potential flu-like symptoms due to IFN-\(\beta\) therapy, the patient was recommended to take 400 mg ibuprofen at least 2 hours before and after the time point of injection. Because he did not recognise any adverse side effects, he first stopped omeprazole medication, which he had taken occasionally, and thereafter the ibuprofen medication. He reassured us that he did not use any other drugs not prescribed by his physicians. Thus, 3 months after initiation of IFN-\(\beta\)-1a treatment the patient was only on this immunomodulatory therapy. One month later, he suddenly developed acute generalised myalgia as well as weakness 1 day after IFN-\(\beta\) application and was therefore referred to the hospital. He denied any antecedent signs of infection or any trauma, but reported going bowling in the evening before the symptoms started. However, there was no difference in the amount of physical exercise compared with other weekly bowling sessions.

If you have a burning desire to respond to a paper published in JNNP why not make use of our “rapid response” option?

Log on to our website (www.jnnp.com), find the paper that interests you, and send your response via email by clicking on the “eletters” option in the box at the top right hand corner.

Providing it isn’t libellous or obscene, it will be posted within 7 days. You can retrieve it by clicking on “read eletters” on our homepage.

The editors will decide as before whether to also publish it in a future paper issue.

At physical examination his heart, lungs, and abdomen seemed normal, whereas neurological examination disclosed a tetraparesis with emphasis on the proximal upper limbs (power 3/5). The muscles were tender to palpation with normal muscle tonus and no increased activity of tendon reflexes. A mild intention tremor at the left arm was pre-existing.

Laboratory findings showed a marked increase in the concentrations of creatine kinase at 6632 U/l (normal range: 5–70 U/l) with normal concentrations of the isofroms CK-MB, lactate dehydrogenase (LDH) at 670 U/l (normal range: 80–240 U/l), and moderately increased liver enzymes, which had been reported since the beginning of IFN-\(\beta\) treatment. Myoglobinuria was not determined and there were no pathological alterations in concentrations of urine nitrogen, reactive protein, blood cell counts, or glucose. No electrolyte abnormalities were detectable.

With the diagnosis of a rhabdomyolysis, IFN-\(\beta\)-1a application was discontinued. The patient was subsequently monitored in the intensive care unit, and treated with intravenous fluids and bicarbonate to maintain an alkaline urine output. Under the treatment myalgia and the tetraparesis disappeared within 2 days. The patient returned to his baseline EDSS. With a delayed time course the creatine kinase declined steadily to normal values after 2 weeks. We now treat this patient with glatiramant acetonide for the relapsing-riming multiple sclerosis.

To our knowledge, this is the first reported case of rhabdomyolysis associated with IFN-\(\beta\)-1a treatment. This adverse event has been previously associated with IFN-\(\alpha\), which also belongs to the type 1 interferons. This, however, exhibits only 30% of homology and differs in its immunological profile. Greenfield et al described a patient 10 weeks after initiation of IFN-\(\alpha\)-treatment starting with 5 MU three times a week for chronic active hepatitis C. 1 and Reinhold et al recorded acute rhabdomyolysis 4 days after high dose IFN-\(\alpha\)-therapy (20 MU/m\(^2\) daily) in a patient with malignant melanoma. 2 Remarkably, the manifestation of muscle injury occurred when the dose of IFN-\(\alpha\) was being increased in both patients described, suggesting that rhabdomyolysis represents at least a dose dependent side effect of this type 1 interferon.

In the patient presented here the dosage of IFN-\(\beta\)-1a was unaltered. Yet, the absence of any other medication, exclusion of infectious and metabolic causes usually related to a non-traumatic rhabdomyolysis, the lack of indications for an underlying metabolic muscle disorder as determined by the patients’ history, the clinical presentation including laboratory investigation, and the temporal relation with IFN-\(\beta\)-1a application indicate that rhabdomyolysis is a possible adverse event of IFN-\(\beta\)-therapy. Rhabdomyolysis can also be induced by unaccustomed muscular exercise in untrained people. 3 However, our patient often goes bowling and thus is used to this programme.

It is concluded that creative kinase activity should be measured when a patient complains of severe myalgia differing from the often occurring myalgia under IFN-\(\beta\)-treatment and, in particular when weakness is reported. This procedure might be effective in the prevention of irreversible rhabdomyolysis during IFN-\(\beta\) therapy. As a dose dependent effect of IFN-\(\beta\)-1a on both clinical and MRI outcomes in relapsing-remitting multiple sclerosis is known, 4 future observations will show whether increase in dosage of IFN-\(\beta\) worsens to rhabdomyolysis as reported for IFN-\(\alpha\).

J D Lüinemann, N Kassim, R Zscherdelein, F Zipp
Division of Neuroimmunology, Department of Neurology, Charité University Hospital, Schumannstrasse 20/21, 10117 Berlin, Germany
B Schwarzenberger
Department of Nephrology, Reinckendorf Hospital, Am Nordgraben 2, 13509 Berlin, Germany
Correspondence to: Dr F Zipp; frauke.zipp@charite.de

References

Supervior sickerosis associated with anterior horn cell dysfunction

Suprerior sickerosis of the CNS is a rare syndrome of progressive cerebellar ataxia and sensorinocural deafness associated with haemosiderin deposition from chronic sub-achondral bleeding. 1 We describe a patient with typical features of suprerior sickerosis and an anterior horn cell syndrome, a combination that to our knowledge has never been previously reported.

A 49 year old man presented with a 4 year progressive history of unsteadiness of gait, bilaterally impaired hearing, and weakness which had begun in the left hand, spreading to involve the left arm and leg, and right hand. He had a 2 year history of cerebellar dysarthria, bladder hesitancy with postmicturition dribbling, and impotence. Examination disclosed a broad based ataxic gait with left sided limb ataxia. Apart from bilateral sensorineural deafness the cranial nerves were normal. There were fasciculations in the arms and legs. In the upper limbs he had asymmetriac wasting and weakness of the intrinsic hand muscles, biceps, and triceps bilaterally. In the lower limb there was wasting and weakness of the hip flexors and quadriceps. Sensory examination was normal. The deep tendon reflexes were all present and symmetric. The abdominal reflexes were present and the plantar responses were flexor.

Magnetic resonance imaging of the brain and spinal cord demonstrated haemosiderin deposition around the cerebellar folia, outlining the whole spinal cord and sacral cut

www.jnnp.com
de sac (fig 1). There were no other abnormalities on the MRI and a carotid and spinal angiogram failed to disclose a source of bleeding within the CNS. The patient declined a lumbar puncture to look for evidence of active haemorrhage. There was no history of CNS trauma or surgery.

Neuropsychological examination showed normal sensorimotor conduction. Motor conduction was essentially normal. Electromyography of the first dorsal interosseus and extensor digitorum communis muscles demonstrated fibrillations and fasciculations with high amplitude units. Somatosensory evoked potentials were normal from the arms but showed delayed latencies in the legs.

A diagnosis of superficial siderosis was made and he was given a trial of subcutaneous desferoxamine fortnightly for 8 weeks with no benefit. The patient has continued to deteriorate.

Superficial siderosis of the CNS is a clinical syndrome characterised by progressive cerebellar ataxia and sensorineural deafness. Pyramidal signs develop in 76% and other pyramidal features that may occur include dementia. Pyramidal signs develop in 76% and other pyramidal features that may occur include dementia. Whether our patient’s presentation was the result of neuronal fallout. In this context our experience with intrathecal baclofen therapy is worth presenting. These two patients are the only ones we have treated in this manner and both experienced a marked improvement in their quality of life.

Figure 1 T2 weighted MRI demonstrating the characteristic rim of hypointensity around the posterior fossa and spinal cord seen in superficial siderosis.

Occasionally the second and seventh cranial nerves are also involved. In addition to the marginal hypointensity created by the paramagnetic ferric ions, high signal in the adjacent cerebellar tissue, due to secondary gliosis, may be seen on T2 weighted MRI.1

The most striking and unique feature of the patient described was the extensive limb wasting and fasciculations with asymmetric weakness but preserved reflexes and an absence of sensory signs. These clinical findings, along with the neurophysiology, suggest an anterior horn cell pathology. In the review of Fearnley et al of 63 patients four had lower motor neuron involvement with absent or diminished reflexes thought to be secondary to arachnoiditis or radiculopathy. One patient had muscle wasting with brisk reflexes thought to be due to concurrent lower motor neuron pathology and myelopathy.1 In our patient the duration of the symptoms and the lack of bulbar and pyramidal features were against this being a classic amyotrophic lateral sclerosis. It is more likely that superficial siderosis was the cause of our patient’s anterior horn cell dysfunction and it is recognised that iron pigmentation may be found deep within the spinal cord and cerebellum. These findings have been described.1 The clinical picture of anterior horn cell damage in superficial siderosis is of particular interest as in the review of Fearnley et al they note that although heavy haemosiderin deposits are recorded in the anterior horns of the spinal cord there is little in the way of neuronal fall out.

The predominance of CNS involvement and the paucity of lower motor neuron features in superficial siderosis has been the subject of several novel studies. Koepen and Borke have shown that an intracisternal injection of red cells produces increased synthesis of ferritin in microglia, especially Bergmann glia in the cerebellum, and this binds with iron to form haemosiderin.2 It is postulated that the glia and astrocytes of the central nervous system respond to the presence of haemoglobin whereas this process does not occur in Schwann cells of the peripheral nervous system. This is supported by the pathological finding that there is a sharp demarcation of haemosiderin deposition in the cranial nerves and spinal roots at the junction of the central glial and peripheral Schwann cell segments. Koepen and Detinger have also suggested that the formation of haemosiderin is neuroprotective and it is once this protection has been breached by unbound iron.3 There are no other case reports of superficial siderosis causing an anterior horn cell syndrome, posing the question of why our patient developed this combination. Whether our patient’s presentation was due to anomalous intracranial processing or an unusual source of haemorrhage impacting on the spinal cord remains speculative. It is also possible that in our case the motor root exit zone is a site of iron deposition with resultant lower motor neuron pathology.

We think that our case of superficial siderosis with anterior horn cell dysfunction is unique, and raises interesting questions about pathological mechanisms in this rare disorder.

B Turner, A J Wills
Division of Clinical Neurology, University Hospital, Queen’s Medical Centre, Nottingham NG7 2UH, UK

Correspondence to: Dr B Turner; msxbt@nottingham.ac.uk

References
4 Koepen AH, Dentinger MP. Brain haemosiderin and superficial siderosis of the central nervous system. Neurol Neurosurg Psychiatry 1988;47:249–70.

Use of intrathecal baclofen for treatment of spasticity in amyotrophic lateral sclerosis

Baclofen, an agonist of γ-aminobutyric acid, is one of the most effective drugs in the treatment of spastic movement disorders. However, higher oral dosages required for sufficient spasticity control are related to intolerable central side effects. In this situation, continuous intrathecal application of baclofen in microgram dosages showed its efficacy in numerous series of patients with spasticity of cerebral or spinal origin.4 Nevertheless, the use of intrathecal administered baclofen in amyotrophic lateral sclerosis, representing the most common degenerative motor neuron disease in adult life, has been mentioned in only one short communication. In this context our experience with intrathecal baclofen therapy is worth presenting. These two patients are the only ones we have treated in this manner and both experienced a marked improvement in their quality of life.

Patient 1, a 25 year old man, was previously reported in brief; he is still alive and benefiting from intrathecal baclofen therapy. Five years ago he noticed progressive gait disturbance, weakness of his right foot, and painful nocturnal cramps in his legs. At that time he exhibited neurologically mild pareses of his right hand and foot, generalised fasciculations, and spasticity. Amyotrophic lateral sclerosis was diagnosed and oral antispastic treatment with baclofen and memantine was started. The patient remained ambulatory but an increase in spasticity due to the underlying disease required subsequent increases in dosage of baclofen. After 1 year a daily dose of 80 mg baclofen was reached but spasticity was no longer ameliorated. The patient was still able to walk a few steps with help but had to use a wheelchair otherwise. Furthermore, he complained of central side effects, such as weakness, daytime fatigue, and sleepiness. Intrathecal baclofen therapy was started, and at a daily dose of 160 μg the patient showed only minimal clinical signs of spasticity. He was able to walk at large without help and could even climb stairs. Spasticity increased during the next 21 months; however, by adjustment of the daily dosage up to 540 μg the patient remained able to walk without additional devices and was capable of caring for himself. Then increasing pareses due to progression of amyotrophic lateral sclerosis came into prominence, and the patient is tetraparetic to a high degree depending on special care. Attempts to reduce baclofen dosage led to a significant increase in spasticity and painful muscle cramps, which resulted in substantial discomfort. Thus a daily dose of 540 μg baclofen was maintained.

Due to bulbar involvement the patient was supplied with a nasofacial mask for non-invasive intermittent ventilation to alleviate
symptoms of nocturnal hypoventilation. He has been followed up now for 49 months, and no complications related to intrathecal baclofen therapy have been seen.

Patient 2, a 39 year old man, experienced progressive pareses resulting in increasing debilitative motor neuron disease characterised by symptoms related to intrathecal baclofen therapy tent ventilation. Recently the patient died necessitated the use of non-invasive intermittent ventilation. Further progress of disease completely in need of care. The major sources of central side effects related to oral baclofen attacks due to uncontrolled spasms and medications. Intrathecal baclofen therapy has been followed up now for 49 months, and symptoms of nocturnal hypoventilation. He has been followed up now for 49 months, and no complications related to intrathecal baclofen therapy have been seen.

As with all other palliative measures, the progressive pareses result in increasing debilitative motor neuron disease characterised by central side effects related to oral baclofen therapy. Recently the patient died necessitated the use of non-invasive intermittent ventilation. Further progress of disease resulted in该院 in need of care. The major sources of central side effects related to oral baclofen attacks due to uncontrolled spasms and medications. Intrathecal baclofen therapy has been followed up now for 49 months, and symptoms of nocturnal hypoventilation. He has been followed up now for 49 months, and no complications related to intrathecal baclofen therapy have been seen.

None the less, quality of life was improved considerably as the patient was able to sleep through the night. Further progress of the disease resulted in rapid development of complete tetraplegia and respiratory insufficiency necessitating the use of non-invasive intermittent ventilation. Recently the patient died after 25 months of follow up. No complications related to intrathecal baclofen therapy had occurred.

Amyotrophic lateral sclerosis is a degenerative motor neuron disease characterised by severe movement disorders. Although progressive pareses result in increasing debilitation of the patient and ultimately death due to respiratory insufficiency, spasticity and painful muscle cramps are disabling symptoms markedly reducing the patient’s quality of life. As the aetiopathogenesis of amyotrophic lateral sclerosis remains unresolved and no cure for the disease is available progress is poor, demanding optimal palliative treatment. As with all other palliative measures, the primary goal is improvement of quality of life rather than life prolongation. Thus, symptomatic treatment comprises a diverse range of medical and physical measures aiming at relieving the specific symptoms of the patient at any point in the continuous progression of the disease. This includes the administration of antispastic agents. Several antispastic drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity but drugs such as baclofen, memantine, or benzodiazepines can effectively relieve spasticity bu...
Authors’ reply:

As Horstink and Bloem suggest, the segregation ratio for men and women is indeed the most appropriate method to calculate the genetic risk for developing a disease. In our recent publication, the sex ratio was calculated from the sample of 15 patients with α-synuclein Parkinson’s disease (α-synPD) included in the study. We now provide additional unpublished data to calculate the segregation ratios and to compare them with the other published series of patients with α-synPD.

In the 10 families examined in our study, 190 members were at risk of developing α-synPD. Of the 103 male members at risk, 27 (26.2%) developed Parkinson’s disease (PD), whereas of the 95 women at risk, 27 (28.4%) developed PD (p = 0.73). When our data were combined with the data computed by Horstink and Bloem, the segregation ratio of all patients with α-synPD was 82/235 (34.9%) for men and 61/191 (31.9%) for women (p = 0.52; table 1).

Golbe et al. had first noted the tendency of the Contursi kindred to have fewer female members at risk for developing α-synPD (male/female ratio 86/56 = 1.5). The female to male ratio of our subjects at risk was 103/95 = 1.08 (p = 0.31 for the difference from 1:1 ratio and p = 0.02 for the difference from 1:1.3 ratio, which is the male to female ratio of the whole population found in the European Parkinson prevalence study). After excluding the Contursi kindred, the male to female ratio of all subjects of Greek origin combined, was 149/135 = 1.10 (p = 0.22 for the difference from 1:1 ratio and p = 0.002 for the difference from 1:1.3 ratio), whereas the male to female ratio of all known subjects at risk of developing α-synPD combined was 235/191 = 1.23 (p = 0.02 for the difference from a 1:1 ratio and p < 0.0001 for the difference from a 1:1.3 ratio).

Our data confirm the finding of Horstink and Bloem that men and women are equally at risk of acquiring α-synPD. The Contursi kindred data are skewing the male to female ratios towards a male predominance. The male to female ratio of our Greek families at risk of developing α-synPD, as well as the ratio of all Greek origin families, did not differ significantly from the 1:1 ratio. However, when the male to female ratios were compared with the expected 1:1 male to female ratio in the general population, a statistical significant male predominance was found. Whether this is due to statistical bias, recall bias, or to genetic or environmental factors remains unclear. The identification of larger numbers of families at risk of developing α-synPD may help to resolve the question.

Table 1 The segregation ratios of all α-synPD cases reported

<table>
<thead>
<tr>
<th>Family members at risk for α-synPD</th>
<th>Male</th>
<th>Female</th>
<th>Male (segregation ratio)</th>
<th>Female (segregation ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papapetropoulos et al.</td>
<td>103</td>
<td>95</td>
<td>27 (26.2%)</td>
<td>27 (28.4%)</td>
</tr>
<tr>
<td>Papadimitriou et al.</td>
<td>14</td>
<td>17</td>
<td>6 (42.8%)</td>
<td>6 (35.3%)</td>
</tr>
<tr>
<td>Golbe et al.</td>
<td>86</td>
<td>56</td>
<td>39 (45.3%)</td>
<td>21 (37.3%)</td>
</tr>
<tr>
<td>Samii et al.</td>
<td>32</td>
<td>23</td>
<td>10 (31.3%)</td>
<td>7 (20.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
<td>191</td>
<td>82 (34.9%)</td>
<td>61 (31.9%)</td>
</tr>
</tbody>
</table>

α-synPD = α-synuclein Parkinson’s disease.

This is a very interesting finding, which raises several issues for the diagnosis and management of sporadic adult onset cerebellar degeneration. I make three comments. Firstly, there is another clinical presentation of ‘Hashimoto’s associated ataxia’, consisting of an acute cerebellar syndrome associated with abnormal behaviour. Protein concentrations are increased in CSF. Brain MRI shows a high intensity signal in T2 weighted images, restricted to the cerebellum. This other presentation should not be overlooked because steroids and thyroid hormonal therapy improve the cerebellar deficits markedly. This ataxic syndrome associated with Hashimoto’s thyroiditis differs from the infarction recently by (1) the acute onset, (2) distinct MRI findings, and (3) the dramatic clinical/radiological response to treatment which is a strong argument in favour of an immune attack against the cerebellum.

The authors should consider multiple system atrophy (MSA) in the differential diagnosis of sporadic adult onset cerebellar degeneration. Various combinations of extrapyramidal, pyramidal, cerebellar, and autonomic features occur in MSA. The disorder having an estimated prevalence ratio of 1.6-1.8/100,000, raised cerebrospinal fluid (CSF) antithyroid antibodies might be a coincidence. Patient 6 exhibited cerebellar deficits associated with autonomic/urinary dysfunction, pyramidal signs (bilateral Babinski’s signs), and parkinsonism (axial rigidity, hyperpnea). Multiple system atrophy is likely in this patient. Were sphincter EMG studies performed? Were dysautonomic signs specifically looked for in other patients?

In one of our patients exhibiting a chronic and sporadic cerebellar syndrome with atrophy, high concentrations of antinuclear antibodies and presence of a rheumatoid factor were initially considered as markers of an immune disease producing a cerebellar degeneration. However, a subsequent genetic testing disclosed a spinocerebellar ataxia type 6 (SCA-6). Genetic analysis for SCA-1 to 7 was performed in one of the patients reported by Selim and Drachman, and was not available in the remaining five patients. Detailed genetic tests should be carried out, even when there is no family history of ataxia. Recent studies show that about 4% of patients with a sporadic ataxia harbour a mutation. Negative genetic results would reinforce the appealing concept of ‘Hashimoto’s associated ataxia’.

Acknowledgements

The author is supported by the Belgian National Research Foundation.

M-U Mantó
Fonds National de la Recherche Scientifique, ULB, 808 Route de Lennik, Bruxelles 1070, Belgium

Correspondence to: Dr M-U Mantó; m.manto@belgium.com

References

neuropsychological account
Conversion hysteria: towards a broader autoimmune diathesis, is unknown. An increase in antithyroid antibodies reflects a role in immune targets such as Purkinje cells, or whether the the six patients we reported. It underlines the importance of immune mechanisms in such cases. It is entirely plausible that this patient shared the same autoimmune diathesis as its underlying mechanism with her. The aim was to bring modern neurocognitive and psychiatric approaches to the subject. For, and here Lewis was surely right, hysteria lingers on in clinical practice, as seen in patients galore, in different settings such as medicolegal practice. Yet the mechanisms leading to the florid manifestations of hysteria in these patients may be part of a psychological tendency available to a much wider population. The wider patient social context should not be even regarded as pathological. The main thrust of the book, and the most relevant for those engaged with such patients, is in an attempt to encapsulate the concept of the Will is debated (another famous quote, from Paget, repeated here: “The patient says he cannot, it looks like he will not, but the truth is that he can’t do it”).

**BOOK REVIEWS**

Conversion hysteria: towards a neuropsychological account


It probably would not have pleased Aubrey Lewis to know that one of his lasting legacies to psychiatry is his now often quoted words from his paper ‘The survival of hysteria’ to the effect that ‘hysteric who will not, but the truth is that he can’t do it’.

This is a comprehensive and up to date textbook about movement disorders in children. All child neurologists and paediatricians with an interest in neuropsychology need to have access to this book and I suspect that most will want to own a personal copy. The addition of this book will be an enormous help to adult neurologists evaluating patients with a movement disorder the origins of which are in childhood or adolescence.

Advances in dementia research


This is a comprehensive collection of presentations from a symposium ‘Ageing and Dementia’ held at the end of 1999 in Graz. As always with such collections, the book is as good as the presenters were and some of these are excellent and useful, others are worth reading. One or two could just have provided an opportunity to go and have a look around Graz. The book is not a systematic review of advances in dementia research and probably books are not good places to turn to for such reviews, as this material is generally best accessed directly from the journals themselves. The book starts well enough with an up to date review of literature scattered throughout neurological and paediatric publications to produce the first text book on movement disorders in children. A clinical approach to movement disorders in childhood is taken with chapters devoted to the predominant movement disorder. Clinical descriptions and illustrations are given for all important conditions producing that movement disorder; comprehensive lists of the rarer causes of movement disorders are also provided.

The authors start by reviewing general concepts relevant to the diagnosis of movement disorders in childhood. The current model of basal ganglia functioning is discussed and this is followed by a description of the main types of movement abnormality. This is followed by a brief, but important, guide to specific areas of clinical history taking and examination in the evaluation of movement disorders in children. Subsequent chapters are based on the predominant movement disorder. Each is organised with an initial introduction and classification followed by a discussion of the major disorders producing similar abnormal movements. Important features of each chapter are a discussion of conditions that may simulate the movement disorder; the discussion of difficult cases according to the authors’ own experience and from the search of the literature; and the description of the treatment of the individual movement disorders. Relevant investigations are also presented within the context of each individual movement disorder. A chapter is also devoted to those complex movement disorders where one type does not predominate. The movement disorders covered include the hypokinetic-rigid syndromes, tremor, chorea, dystonia, myoclonus, tics, and complex. There are also important chapters on dystonia, movement disorders and movement disorders in cerebral palsy. Last is a chapter about ancillary investigations that either have, or may well in the future, prove useful in our understanding of paediatric movement disorders. Throughout the book, additional authors have contributed their own expertise. This is a comprehensive and up to date book of essential interest to all child neurologists, paediatricians and neurologists with an interest in neurology or neurodisability who have access to this book and I suspect that most will want to own a personal copy. The addition of this book will be an enormous help to adult neurologists evaluating patients with a movement disorder the origins of which are in childhood or adolescence.

R Surtees
example includes no discussion of transgenic models of the frontal lobe dementias even though that is clearly related and the various papers on immunological approaches do not include any of the amyloid vaccine data. A more general question arises, to my mind, however, reading this book, as to quite who else is likely to read it. If read by somebody coming new to the dementia field they would have a very unbalanced picture of the field and this is not be recommended to novices to dementia research. On the other hand, those familiar with dementia research are unlikely to treat this book as other than a collection of primary papers and if browsing, this might well be better done with JNPP, for example. The participants of the meeting are almost certainly to flick through the book if only to recall what they said. Other readers of course will include reviewers. However, and this is a very personal review, I am not a huge fan of collection of papers from meetings. I suspect they largely go unread and I cannot really recommend this book to anybody. Interestingly the final six or so papers from a proprietary compound which is being developed for treating Alzheimer's disease. According to one article, this compound is widely used to relieve symptoms in various neurological disorders, which with my limited experience. The chapters on structural and functional imaging. Subsequent chapters treat different aspects of limbic seizures—language disturbances, motor automatism, impairment of consciousness, autonomic changes, and postural changes. The literature distinguishing frontal seizures is summarised. There are chapters on structural and functional imaging. This book arose out of a colloquium. Of the 26 contributions, all but four are from French or Italian centres. The two from America are particularly good and perhaps the standard of the rest might have been higher if the net had been spread wider. Some authors speak from very limited experience. The chapters on treatment are particularly disappointingly that systematic errors in English abound and treatment are particularly disappointing. That systematic errors in English abound and much information is repeated throughout implies lack of adequately firm editorial grip. This book will be useful to paediatric epileptologists, but the patchy quality overall precludes a warm recommendation to a wider audience.

Simon Lovestone

Limbic seizures in children


Limbic seizures in childhood differ from those in adults. They are more likely to be caused by cortical dysplasias, related malformations, and tumours. They are more easily, but not invariably, controlled by drugs. Have new imaging and EEG techniques advanced the activity of certain hippocampal circuits on which its function is contingent make it particularly liable to epileptogenesis. Many patients with catastrophic epilepsy do not have MTS. Seizures themselves do not cause MTS. Some per cent of patients with MTS have dual pathology, 15% have increased neuronal heterotopias, and 15% have bilateral involvement. Degree of cell loss is not related to duration of epilepsy. Mossy fibre sprouting is not seen in children younger than 10 years, suggesting that this is a secondary progressive lesion. From facts such as these Spencer et al conclude that mesial temporal lobe epilepsy has a probable developmental aetiology. Hippocampal abnormalities pre-exist (and can be demonstrated in unaffected members of familial temporal lobe pedigrees) but convey vulnerability to febrile convulsions and subsequent MTS. Subsequent chapters treat different aspects of limbic seizures—language disturbances, motor automatism, impairment of consciousness, autonomic changes, and postural changes. The literature distinguishing frontal seizures is summarised. There are chapters on structural and functional imaging. This book arose out of a colloquium. Of the 26 contributions, all but four are from French or Italian centres. The two from America are particularly good and perhaps the standard of the rest might have been higher if the net had been spread wider. Some authors speak from very limited experience. The chapters on treatment are particularly disappointing. That systematic errors in English abound and much information is repeated throughout implies lack of adequately firm editorial grip. This book will be useful to paediatric epileptologists, but the patchy quality overall precludes a warm recommendation to a wider audience.

Richard Robinson

Spinal cord injury desk reference. Guidelines for life care planning and case management


This is a reference text. It contains information that will be of considerable assistance to those who are involved in the planning of the long term care of those with spinal cord injury in the United States. The authors, all United States based, include two spinal cord injury physicians, a behavioural scientist, and a rehabilitation counsellor. The information in this book will assist predominate those healthcare professionals who are closely involved in the case management of spinal cord injury. It will also be of interest to all those who are involved with spinal cord injury including patients, their families, and all the many groups who work in the area including doctors, nurses, therapists, healthcare plan- ners, lawyers, and many others. For those who already have wide knowledge of spinal cord injury care the chapter on resources and legislation may be of particular value as it contains numerous addresses and telephone contacts.

Even though the specific information in this book is relevant to the United States, many outside that country will find the book of interest, perhaps encouraging them to seek the comparable data relevant to their own countries. The information contained in texts such as this is a prerequisite ensuring that there is adequate appropriate long term provision for people with spinal cord injury, especially as they age. Inevitably in a wide ranging book there are weaknesses. For example, the debilitating orthostatic hypotension induced fatigue and coat hanger pain experienced by many persons with higher level spinal cord injury is not mentioned and the 1993 rather than the more complete 1998 United Kingdom life expectancy data are used. These omissions do not detract from the importance of this book's attempt to fill an important niche that has not been adequately addressed before. It would be of great interest if similar texts were produced in other countries. Not only would this help improve long term care in these countries but it would also enable comparisons of costs and approaches to care to be made that would assist the improving systems of care for patients with spinal cord injury worldwide.

Brian Gardner

Head trauma: basic, preclinical, and clinical directions


Miller and Hayes have assembled chapters from 42 expert contributors renowned for their work in investigation of traumatic brain injury. They have divided the text into three main sections, basic science: overview, preclinical studies, and clinical directions. Organising the text in this way authors have struck a theme which passes from experimental concepts through to preclinical feasibility studies and eventually on to clinical trials. They acknowledge from the outset that the wealth of basic scientific information gathered over the past 3 decades has not led to substantial clinical gain. The reasons for this are debated in a latter chapter. The work represents a comprehensive review of the information available on traumatic brain injury. The basic science overview I found to be particularly well written and concise, introducing concepts and experimental data in a highly readable way. The main theories of cytotoxicity, inflammatory response, apoptosis, traumatic axonal injury, and mitochondrial dysfunction have separate attention, as do the important vascular aspects of severe head injury. The final section refers to the clinical efforts of attempting to translate scientific knowledge into clinical work. The vast number of clinical trials organised in the United States, Europe, and Asia are discussed and potential reasons for their failure debated. In success, for example, the work of Miller and Hayes is a valuable addition to the reading of those involved in traumatic brain injury. This is particularly so for those who engage in the experimental and clinical design of novel therapies for the traumatised brain.

Peter J Kirkpatrick
Meeting the challenge of progressive multiple sclerosis


Having been diagnosed in 1982 I have lived for 19 years with a slowly progressive form of multiple sclerosis. I was therefore glad of the opportunity to catch up on recent developments in the understanding of the disease and discussion of some of the latest options for treatment. Although the book states in the opening paragraph that it is written for people with this form of multiple sclerosis, it is also obvious from the first page that it is going to be very hard work for anyone without a scientific or medical background to make sense of the information it contains. I constantly found myself having to reread and struggle to understand the technical language used throughout the book. Such a pity when there is much potentially useful information there.

I was interested to see what the writers would have to say in the section on management and self help since this is an area the medical profession has often overlooked. There is discussion under various headings such as coping with fatigue, bladder dysfunction, tremor, and cognitive dysfunction, followed in each case by a series of bullet points on the management of symptoms. Once again the language defeats the object of the book as these read more like checklists for doctors and multiple sclerosis nurses than clear, accessible summaries that people with multiple sclerosis can make use of.

It is heartening to see that in these days of disability legislation (the Disabilities Act in the United States and the Disability Discrimination Act in the United Kingdom) questions of access to buildings and equipment and discussions of legal rights and financial entitlements are seen as having a place in a book on multiple sclerosis. The past 19 years have taught me that factors such as attitudes towards disabled people, the design of buildings, and the way in which services are delivered may impact on the lives of people with multiple sclerosis and their families just as much as the effects of the disease.

Michele Wates
Superficial siderosis associated with anterior horn cell dysfunction

B Turner and A J Wills

J Neurol Neurosurg Psychiatry 2002 72: 274-275
doi: 10.1136/jnnp.72.2.274-a