Mexiletine on segmental hyperhidrosis

Ishibashi et al. reported the excellent efficacy of mexiletine for the treatment of segmental hyperhidrosis in two patients (who had syringomyelia and cavernous haemangioma of the spinal cord, respectively). They presented the decrement in the patients’ sweat rate by oral administration of mexiletine.1

Previously we performed a clinical study focusing on sweating and identified 10 patients with segmental hyperhidrosis among 30 patients with syringomyelia. We followed up the patients with hyperhidrosis for 1–10 (mean 5.0) years. The amount of sweating did not change in any of them during the follow up period, although we did not perform a quantitative analysis. Consequently, we speculated that hyperhidrosis persists for at least a year. It is possible that the course of sign/s in the cases reported by Ishibashi et al. were modified by the growth or activity of spinal cord lesions. We consider it imperative that these authors describe any spinal cord lesions and how they may have shifted. However, although they did not mention the duration and time courses of the improvement in their patients, we suppose that the duration of the follow up for each patient would not have exceeded several months, judging from how the authors described their experience. In addition, even though they did not test the effects of mexiletine on control subjects or on other parts of the body in the same patients, we can be assured that the improvement in hyperhidrosis was due to the oral administration of mexiletine, on the assumption that the spinal cord tumour could not have changed in such a short time. We consider that it would be informative for clinicians if Ishibashi et al. were to disclose the drug dosage and the time course of its effects and to describe the features of the spinal cord lesions.

K Sudo, Y Miyazaki, Y Tajima, A Matsumoto
Department of Neurology, Sapporo City General Hospital, Kit 11, Nishi 15, Sapporo, 060-8604 Japan

K Tashiro, F Moriwaka
Department of Neurology, Hokkaido University School of Medicine, Sapporo, 060–8648, Japan

Correspondence to: Dr K Sudo; sudo@med.hokudai.ac.jp

References

Authors’ reply
We are grateful Sudo et al., as they allow us to clarify a point of our study that was not discussed in the paper recently published in this Journal. They asked about the possibility of natural remission and the non-specific effect of mexiletine on sweating.

We administered 200 mg/day mexiletine or 400 mg/day carbamazepine to our patients. Both patients noticed their hyperhidrosis was relieved within two days after administration. Although we did not perform a quantitative analysis several months after treatment, the clinical improvement of hyperhidrosis persisted. In addition, the magnetic resonance images of spinal cord lesions (syringomyelia and cavernous haemangioma) in both patients were followed up for two years. During the follow up period, the spinal cord lesions did not change their size, position, and intensity on magnetic resonance imaging. Therefore, the natural course of the spinal cord lesions could not explain the improvement of hyperhidrosis during the treatment and quantitative analysis in our patients.

The sweat rate of the area of observed hyperhidrosis was decreased without a change of the ratio of the sweat rate on the healthy side after oral administration of mexiletine. We calculated the ratio of the sweat rate on the affected side to that on the healthy side—the ratio was 2.13 before treatment and decreased to 0.97 on day 7 after the treatment. We therefore consider that the mexiletine had an excellent effect only on the area with hyperhidrosis. Although we did not test the effects of mexiletine on control subjects, we think that the result on a healthy area of each patient was an appropriate internal control for the evaluation of the drug’s effect on hyperhidrosis.

S Ishibashi, T Yokota
Department of Neurology and Neurological Science, Graduate School of Medicine, Tokyo Medical and Dental University, 1-5-45, Yushima, Bunkyo-ku, Tokyo 113-8519, Japan

Correspondence to: Dr T Yokota; yok-yokota.nuro@md.ac.jp

References

Authors’ reply
We thank Dr Demetriades for his comments on our study. While the average person with a patent foramen ovale (PFO) may not be at increased risk for neurological events, there seem to be subgroups of patients at increased risk. PFOs with large diameters, right to left shunting at rest, or high membrane mobility and PFOs associated with atrial septal aneurysms have been identified as “dangerous PFOs” by several investigators.1-3 In addition, coagulation abnormalities may promote paradoxical emboli in patients with PFOs.4 To this list, Dr Demetriades adds special occupations or sports that may be dangerous in people with PFOs, specifically divers. Playing wind instruments has also been mentioned previously.5-6 However, many problems related to PFO remain unresolved. Even in groups that are believed to be at high risk for neurological events, deciding whether and how to treat a PFO cannot be derived from evidence based medicine. Deciding how to proceed depends on the opinion of the attending physician and is not based on data from randomized studies.

The PICSS (PFO in cryptogenic stroke study) showed that secondary prevention of cryptogenic stroke in patients with PFO by using warfarin or aspirin does not result in any difference.7 The PC-trial is an ongoing randomised trial we initiated to compare

A K Demetriades
The National Hospital for Neurology and Neurosurgery, Queen Square, London WC1N 3BG, UK

Correspondence to: Dr A K Demetriades; andreas.demetriades@doctors.org.uk

References
Demyelination in the brain as a paraneoplastic disorder: candidates include some cases of seminoma and central nervous system lymphoma

We read with interest the report of Ayuso-Peralta et al.,1 which describes a 58 year old woman who presented with several neurological symptoms. Brain imaging was consistent with leukoencephalopathy, and analysis of blood and cerebral spinal fluid was unremarkable. A few months later the patient experienced further mental deterioration, and an open brain biopsy showed central nervous system (CNS) lymphoma, together with diffuse demyelination.

The authors observed that the presentation of cerebral lymphoma as a diffuse leukoencephalopathy is not frequent and they discuss possible pathologies in the predominant demyelination in their case. They do not mention the possibility of a paraneoplastic aetiology.

The authors reference a similar case previously reported in the Journal. That report also does not acknowledge a possible paraneoplastic aetiology for diffuse brain demyelination exceeding the discovery of CNS lymphoma. Two other recent reports in the Journal2,3 described focal tumour-like lesions in the brain associated with seminoma, probably because the temporal association was close and the spatial association was distant.

The associations between brain demyelination and CNS lymphoma have been close, both temporally and spatially, making consideration of aetiology more complex. Taken together, the seminoma reports and the CNS lymphoma reports have many similarities in their patterns of associated brain demyelination, raising the possibility of similar mechanisms of demyelination. Many questions concerning aetiology remain unanswered. Given the information available, we suspect a paraneoplastic aetiology in all of these cases. We feel that future reports of brain demyelination associated with CNS lymphoma should consider this possibility in their data collection and in their discussion of results.

J H Jaster
Delta Medical Center, 1905 Habert Avenue, Memphis, Tennessee 38104, USA

Reference

References

www.jnnp.com
Risk control and quality management in neurosurgery


This is an interesting and timely publication. The book contains a compilation of material presented at an international meeting held in October 2002. It has been divided into various sections that take the reader through grouped papers and topics and finally a projection into the future. As would be expected, the material covers experience and lessons gained in other areas such as aviation and nuclear research. The authors, generally senior in status, originate from Europe, the United States, and the United Kingdom and therefore offer a diverse collection of views, opinions, and experience relevant to a very wide readership. The increasing requirements for quality assessment and competency make this a very valuable reference book for both departmental and institutional libraries. However, it certainly will be of value to individual readers, though it is recommended reading for trainees to understand the principles and the ongoing thought behind many of the practices and control measures that they will encounter and will need to participate in as their experience and seniority advance. The quality of contributions and the outline of the information do vary, as would be expected in such a compilation, but overall very few pages or chapters do not prove insightful nor provide information and guidelines. It will be of value to all medical disciplines, since the principles are universal and the terms of reference or yardsticks used are convertible or transferable. It is highly recommended.

J Van Dellen

Primary progressive multiple sclerosis


The field of multiple sclerosis (MS) is awash with literature on every aspect of the disease ranging from epidemiology and genetics to pathology and treatments. It is unusual, therefore, to find a lucid in this niche but this book seems to have found one.

Primary progressive multiple sclerosis is written to encapsulate the latest evidence on aspects of this condition, which until recently was not regarded as important in understanding demyelinating disease. Filippi and Como have brought together all the important players in the study of primary progressive MS. Their contributions summarise the latest information on the epidemiology, genetics, immunology, pathology, imaging, and clinical trials and therapies in primary progressive MS. This book is meant to be a useful guide to the subject and does not perversely be an authoritative account. However, it occasionally is a little too brief in its explanations and definitely lacks pictures, tables, and diagrams in the early parts of the book. It makes it a rather bland and dry account initially. When the diagrams and scanned images do appear in the later parts of the book, many of them lack definition and it is not always easy to see the details that are being referred to.

Steven Rose

Multiple sclerosis: a guide for the newly diagnosed, 2nd edn


This book is an invaluable guide for patients with multiple sclerosis (MS), as well as their friends and families. The fact that a second edition has become necessary is extremely encouraging for those involved with MS and highlights the recent therapeutic advances for this still devastating diagnosis. Most people who develop MS are desperate for information about their new disease and many turn to the internet to find it. Unfortunately, they are then faced with misleading or simply incorrect information, which can leave patients confused or disillusioned.

The authors present detailed information in the first two chapters covering the pathological processes causing the symptoms of MS and the diagnostic tests in use. Uncertainties in both these fields are explained. The next two chapters deal with treatments, including conventional and alternative or complementary therapies; the text is clear about the lack of a cure for MS but discusses all the options including steroids for acute attacks, disease modifying drugs, and symptomatic treatments. There is a whole chapter on the important issues of lifestyle—diet, rest, sexual function, pregnancy, etc.—that help patients to control their condition. A further chapter concentrates on the psychological impact of a diagnosis of MS and its effect on relationships. Employment issues are deservedly dealt with on their own, with practical advice on when and how to disclose the diagnosis and the legal implications of disclosure both at work and in application forms such as those for health and life insurance.

The latter part of the book deals with clinical and research trials in MS that will help patients to understand how trials are designed and why treatments are offered to patients with specific disease types. The many fields in which MS research is ongoing are discussed and the questions being asked by investigators are well presented.

The book ends with more practical advice on how to get further information about specific topics; however, this is predominantly aimed at the North American readership with emphasis on the MS societies of the United States and Canada.

In summary, this is an excellent book, which presents all the facts in a straightforward but sympathetic way. As well as the medical facts about the disease, it is full of practical advice covering all life topics, areas that are often neglected by busy physicians. It is highly recommended to all those whose lives have been affected by this disease.

Valerie Stevenson
Disordered mind and brain: the neural basis of mental symptoms


The premise of this book is that the key to understanding the neural basis of the major mental disorders is an understanding of the origin of five symptom clusters or dimensions common to these disorders. These are reality distortion (hallucinations and delusions); disorganisation (of thought and behaviour); psychomotor poverty and excitation; depression and elation; and anxiety. Thus, there are five chapters each devoted to a description of a specific dimension and an exposition of how it is correlated with cognitive abnormalities derived from the dysfunction of specific neural processes.

These central chapters are preceded by five chapters describing the neuroscience of brain systems thought to be involved in generating the various symptom clusters. These are brief and the literature reviews are in no way comprehensive. Nevertheless, they serve the purpose of informing the reader of the basic neuroanatomical and neurophysiological concepts that underpin Professor Liddle’s approach to understanding mental illness.

The final four chapters summarise the current evidence regarding the neurobiology of schizophrenia, bipolar affective disorder, obsessive compulsive disorder, and psychopathy. Each ends with a synthesis that integrates this with the previous account of how the symptom clusters arise.

The explanatory power of Professor Liddle’s thesis concerning the neural basis of mental symptoms is stronger for some symptom dimensions, such as reality distortion, than others, such as disorganisation. But it is the general unifying approach that is the major strength of this book—the detail will certainly be honed over the next decade. Another strength is that this is a self-contained book! It assumes no neuroscientific or medical knowledge other than the most basic. There are many excellent colour illustrations. Therefore, this book can be highly recommended to anybody interested in the disordered mind and brain.

Eileen Joyce

CORRECTIONS


Due to the style used in house for listing authors affiliations in the Letters section of the journal, the author’s names have been incorrectly listed. The correct order should read as follows:


This also applies to:


The correct order of the authors is: Lünemann JD, Schwarzenberger B, Kassim N, Zschenderlein R, Zipp F.

Aarsland D et al. Donepezil for cognitive impairment in Parkinson’s disease: a randomised controlled study. J Neurol Neurosurg Psychiatry 2002;72:708–12. An error occurred in the production process in which the codes of the two lines were erroneously interchanged. The correct figure appears below:

Figure 2 Change in mini mental state examination (MMSE) score from baseline over the two treatment sequences. Values are mean (SE).
Genotype predisposition to leukoaraiosis

Z Szolnoki, M Szabó and F Somogyvári

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doi: 10.1136/jnnp.73.3.352-a

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CORRESPONDENCE

Measuring carotid stenosis

Comparing a new test with a standard involves measuring disagreement. In the case of measuring carotid artery stenosis, some of the disagreement between different tests is because of inherent differences in how the stenosis is demonstrated (test characteristics). This is what we are most interested in when assessing a new technology. However, some of the disagreement simply reflects variability in how we physically make the measurement with the standard technique. Choosing the point of maximum stenosis, choosing the point in the common carotid artery for use as a denominator, measuring from an eyepiece, or measuring from calipers all introduce variation when measuring carotid stenosis. The resulting observer variabil-

ity in reporting contributes to disagreement between methods but to some extent is inde-

pendent of the method used to generate the angiogram in the first place.

In the medical literature, disagreement between methods is often attributed entirely to test characteristics, with little appreciation of the role of observer variability in reporting. When one method is compared with another all disagreements emerge, it is not readily apparent how much of the disagreement is caused by the method used and how much by the process of measurement, unless observer variability data are presented but their signifi-

cance in relation to overall agreement does not appear to have been appreciated.

Using the data from Patel et al (tables 2 and 4) for symptomatic carotid arteries, it is noted that when 34 carotid digital subtraction angiograms (DSAs) are measured by one radiolo-

gist, there was disagreement in seven cases when the same films were reported by a second radiologist. Therefore if only DSA was used, seven patients would have had “inap-

propriate” surgery according to which radiologist read the angiogram. This is not surprising, and such disagreement is a con-

sistent finding in observer variability studies.1 Observer variability in reporting DSA therefore accounted for approximately 20% of disagreement in this particular series of angiograms. This sets a limit on the maximum agreement that any alternative method can demonstrate when compared with DSA. It is clearly not reasonable to expect better agreement from another method than can be obtained by re-reporting the DSAs themselves. In Patel’s table 2, when the same arteriers are assessed by computed tomogra-

phic angiography (CTA) there was dis-

agreement with DSA in seven cases, while with magnetic resonance angiography (MRA) and ultrasound there was disagreement in six and seven cases, respectively. The three alterna-
tives thus disagree with DSA to the same extent as can be attributed to observer disagreement in reporting DSA. Put simply, the same number of missed or unnecessary operations would have occurred (roughly 20% in this series) whatever method was used, including DSA alone. Observer variability is

not confined to DSA, and the scatter plots from Patel et al (fig 2) would suggest—in keeping with other studies—that observer variability is greater for MRA and CTA than for DSA.2 It is surprising that this did not translate into more clinically important disa-

greements when MRA and CTA were com-
pared with DSA. This is probably accounted for by the fact that in this study, for MRA and CTA, consensus views were taken for any disagreements greater than 10% between observers.

This highlights the important point that combining multiple observations made on the same data will reduce observer variability, and ultimately improve agreement with other methods. Partly for this reason, but also because to some extent the strengths and weaknesses of CTA, MRA, and duplex ultra-

sound are complementary, we would suggest that a combination of ultrasound and MRA should be used in preference to DSA.

What is clear from this study is that most of the disagreement arises from different meth-

ods of measuring carotid stenosis can be attributed to observer variability in reporting rather than to the test characteristics of the individual methods themselves. The 10% of patients injured as a result of DSA in this study, and those who continue to be put at risk from catheter angiography in these circumstances, would be quite entitled to ask why they are exposed to a procedure which appears to offer no great advantage over safer alternatives. We suggest that more studies are not required, simply a more thorough under-

standing of presently available information.

G Young
Middlesbrough General Hospital, Ayresome Green Lane, Middlesbrough TS5 5AZ, UK

P Humphrey
The Walton Centre, NHS Trust, Liverpool, UK

Correspondence to: Dr G Young; gavin.young@stees.nhs.uk

References

1 Patel SG, Collie DA, Wardlaw JM, et al. Outcome, observer reliability, and patient preferences if CTA, MRA, or Doppler ultrasound were used, individually or together, instead of digital subtraction angiography before carotid endarterectomy. J Neurol Neurosurg Psychiatry 2002;73:21–8.


Author’s reply

Doctors Young and Humphrey highlight that differences between tests arise from several factors, some of which are inherent in the test and some of which arise from aspects attributable to observer variation. Some of the aspects to do with observer variation apply to
terpretation of all tests and some are specific to certain tests. In our study we were endeavouring to quantify the effect on patient management if non-invasive tests were used instead of intra-arterial angiography to assess carotid stenosis. Our study has several limita-
tions, including a relatively small sample size and the fact that we were not able to get all scans read by all observers but rather had to get pairs of observers to concentrate on read-

ing only CTA, or MRA, or DSA. A better design would have been to keep the same workers together in pairs but randomly assign the CTA, MRA, or DSA films to each pair. As it is, it is possible that some of the apparent differ-

ces between imaging modalities is specific to the pair of observers, not to the modality. However, imaging studies are difficult to fund and expensive to do, and the result and design of our study was a compromise involving all these factors.

We identified that the observer reliability of CT angiography or MR angiography was worse than that for digital subtraction angiography, as highlighted by Drs Young and Humphrey. Also in general there was more variability between the observers for the reading of asymptomatic stenoses than for sympto-

matic stenoses (emphasising the importance of considering patient characteristics, not just the imaging technique). In the determination of the effect that this disagreement might have on patient management, we used nomo-
grams derived from the European carotid sur-

gery trial which were based on intra-arterial angiographic measurement of stenosis. We therefore had to use the comparison of non-invasive test reading with DSA rather than being able to use the individual observ-

ers readings of non-invasive tests. Thus as Drs Young and Humphrey point out, the actual effect of using non-invasive tests maybe worse than we have estimated.

Finally, Drs Young and Humphrey suggest that more studies are not required but we are not entirely sure that that is completely true. Non-invasive imaging tests are continually undergoing modifications, may improve in accuracy or practi-

cality, but this cannot be assumed to be the case. Much of this tinkering with technology is driven by the manufacturer’s desire to encourage purchase of new machines. Improvements have also occurred in intra-

arterial angiography with smaller and more manoeuvrable catheters and greater aware-

ness of the risks, which may have helped to reduce the risk of angiography. Our “snap shot” of CTA, MRA, and ultrasound is already out of date because contrast MRA is now increasingly used. While we would hope that non-invasive tests (probably in combination rather than alone) would eventually replace intra-arterial angiography in the majority of patients being considered for carotid inter-

vention, we feel it likely that there will always be a need for some intra-arterial angiography in specific cases, or depending on local resources. In any case DSA did not fall any less popular than MRA among the patients in our study. There is certainly room for much more in depth examination of existing data but we shouldn’t close the door on the need for further studies.

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Cerebral metastasis after primary renal cell carcinoma

The article by Roser et al., in which it was shown that the treatment of intracranial metastases originating from renal cell carcinoma can on occasion be successful, was most interesting.

We have followed the clinical course of a patient with a renal cell carcinoma with a low mitotic index since 1989. In this patient the course was distinctly more malignant but the disease has also been successfully treated to date. In the last 13 years, this patient has had four metastases surgically removed and a further nine treated with stereotactically guided percutaneous single dose convergent beam irradiation therapy (stereotactic modified linear accelerator, 6–15 MV photons, 18–20 Gy prescribed to the 80% isodose). Apart from slight mnemonic deficits, the patient is in good health.

The following factors which affect the prognosis were all met by our patient:

- The interval between the diagnosis of renal cell carcinoma and the first detected brain metastasis exceeds 17 months (our patient, 18 months; the patient described by Roser et al., 36 months);
- Age below 60 years at the time of initial diagnosis;
- Primary tumour of the left kidney, initial nephrectomy;
- Diameter of primary metastasis < 2 cm;
- Not more than one brain metastasis at the time of initial treatment;
- Solely intracranial metastases;
- Karnofsky > 70%;
- No systemic symptoms such as fever or weight loss at the time of diagnosis;
- Blood sedimentation rate under 50 mm/h at diagnosis of renal cell carcinoma.

Patients in whom prognostic factors predict a good outcome should be treated with intent to cure.

S Heckl
Department of Neuroradiology, University of Heidelberg Medical School, Klinikum, In Neuenheimer Feld 400, 69120 Heidelberg, Germany

K Braun, J Debus
Department of Radiation Oncology, German Cancer Research Centre, Heidelberg

S Kunze
Department of Neurosurgery, University of Heidelberg

Correspondence to: Dr med Stefan Heckl; s.heckl@kdz.uni-heidelberg.de

References

BOOK REVIEWS

Seizures, medical causes and management

This book is unusual among books about seizures because it focuses on acute symptomatic (“situation-related”) seizures, rather than “epilepsy” (although there is inevitably some overlap between the two). It provides definitions and describes the epidemiology and pathophysiology of acute symptomatic seizures in the initial section, which is followed by chapters detailing the specific circumstances in which such seizures are likely to occur, often (although not invariably) including points of management specific to the situation. Subjects covered include seizures occurring in the context of multisystem disease, infection, hypoxic-ischaemic cardiopulmonary conditions, endocrine disorders, cancer, and other conditions. Situation-related seizures occurring as a result of drugs or alcohol misuse are also addressed, as are those occurring in the intensive care situation, and the difficult, but important, differentiation of seizures from syncope. The book ends with a very practical chapter entitled “Antiepileptics in acute medical illnesses”, in which the considerations affecting the choice of antiepileptic drug in the acute situation are reviewed.

Although situation-related seizures are usually discussed in books about epilepsy, they do appear to constitute a distinct group in a number of respects including prognosis. To a certain extent the topics discussed in the book form a rather disparate group linked only by their tendency to cause such seizures as a reflection of central nervous system disturbance. Nevertheless, they are all conditions likely to be encountered at various times by general physicians, neurologists, and those working in the accident and emergency department, and this book, which is both readable and comprehensively referenced, will be of interest to all these groups.

Yvonne Hart
Subcortical stroke, 2nd edition

This is a very useful, reasonably comprehensive yet succinct multiauthor small book on medical risks associated with epilepsy. Areas covered include methodological aspects; accidents and risks in everyday life; traffic accidents; driving regulations; mortality, including SUDEP; psychiatric comorbidity and suicide; fatal adverse drug reactions reporting data (which are rather difficult to interpret); seizure-warning systems and risk prevention; as well as insurance related issues. It also highlights many areas where further research is required. The book generally provides an overview of the more recent research and publications in this area and includes some regulatory issues. Inevitably it has a Nordic emphasis; it includes very useful advice on precautionary measures to minimise risk of injury for people with uncontrolled epilepsy, including a sauna. Some chapters, by necessity, serve purely as available incomplete data. Others are written by key researchers directly involved in the area addressed and provide a very balanced review of current knowledge. On psychiatric comorbidity, while agreeing that “the positive
effects of drug therapy on cognitive and affective functioning because of the reduction in seizure activity are usually far greater than the negative effects”, more information would have been welcome in an otherwise very well balanced chapter. The book would well serve those for whom it is intended, namely pathologists, neurologists, paediatric neurologists, psychiatrists, and other professionals who deal with patients with epilepsy. The editors rightly stress the “official line” that the majority of patients with epilepsy can achieve good control, with low associated risks.

Lina Nashef

Greenfield’s neuropathology, 7th edition


What can one say. The latest (7th) edition of Greenfield’s Neuropathology has hit the bookshops, and indeed what a resounding thud it makes! The present edition is bigger than ever, again running into two volumes, but now totalling a staggering 2330 pages and costing an equally staggering £145. It comes equipped with a handy CD version of the illustrations, a mere snip at £145.

The 7th edition has undergone considerable changes in content, since the last edition five years ago, reflecting the ever expanding increase in knowledge of diseases of the nervous system and muscle that has come from the exponential growth in neuroscience research over the past decade. Areas of cellular and molecular neurobiology, and the contributions that genetics and neuroimaging have made towards improving our understanding of the causes of disease and our clinical investigative and diagnostic skills, are more strongly featured. Hence, while greater emphasis has been placed on the basic science of disease, the classic descriptive morphology for which Greenfield is renown is well maintained. There are new chapters on “Metabolic and neurodegenerative diseases of childhood” and “Peroxisomal and mitochondrial diseases”. The chapter on “Pathology of schizophrenia” has been shrewdly expanded to cover “The pathology of psychiatric disorders”. Other chapters have been retained as such, but many have been rewritten with new authors reflecting the pre-eminence of each within their particular subspecialty. There is increased reliance on colour illustrations, line diagrams and tables to illuminate the text, and these are of excellent quality throughout. As to be expected, all chapters are written authoritatively with clarity and style, comprehensively illustrated, and lavishly referenced. Judging by the content of the chapters on ageing and dementia, prion disease, and movement disorders, it is my guess that if anything is not included in each chapter, it’s probably not worth including anyway. The accompanying CD rom is user friendly, and the images are downloadable—a boon to those wishing to produce a ready made lecture or presentation of distinction. The book is a must for practicing and trainee pathologists, but is equally compelling for workers in other clinical neuroscience disciplines and basic researchers interested in the roots of the dysfunctional nervous system. Possession of the 7th edition is guaranteed lasting quality and full value, but before lashing out make sure both your arms and shelves are strong enough to accommodate its presence.

David MA Mann

Smell and taste complaints


Despite the fact that problems with tasting and smelling are common in the general population, few physicians have the knowledge and training to authoritatively deal with them. Christopher Hawke’s Smell and Taste Complaints provides a straightforward guide to the understanding and management of chemosensory disturbances, reflecting the first clinically oriented book of its kind since Ellis Donck’s The Sense of Smell and its Abnormalities (Edinburgh: Churchill Livingstone, 1974). This 180 page pocket sized book provides a cogent overview of the anatomy and physiology of the olfactory and gustatory systems, practical approaches towards their assessment, and suggestions for therapy and management. Importantly, it provides the practitioner with the names and addresses of specialised taste and smell clinics throughout the world, aiding the referral process. Although there is little new in this guide, and much of the material seems to have been derived from second hand sources, it presents the available information in a well organised and easy to read manner. Moreover, it addresses basic clinical issues rarely addressed in a single publication. Its major drawback is the lack of reference backing for many of its statements, some of which are questionable. I found, for example, some of the “facts” unfamiliar, and would have welcomed knowledge of their source. Bits of the material are dated (for example, the role of IP, receptors in olfactory function, the nature of olfactory receptor cell regeneration) and several sections of the book seem lengthy, uncritical, and of little practical value. Thus, nearly seven pages are devoted to the topic of odour memory, a topic with inherent theoretical issues and problems that are not addressed by the author. However, the book is not intended to be a research book and, despite such shortcomings, it accomplishes its goal of educating the practitioner and providing him or her with a practical roadmap for clinical assessment and treatment. Indeed, the clinical information provided is comprehensive and well illustrated. This inexpensive book is a must for any physician who has the occasion to see patients with chemosensory disturbances or has even a casual interest in chemosensation, and should serve to elevate the level of appreciation of these senses within the medical community at large.

Richard L Doty

CORRECTIONS

The following errors occurred in the short report by Merlisi L, Carbone I, Capanni C, et al. Familial isolated hyperCKaemia associated with a new mutation in the caveolin-3 (CAV-3) gene. J Neurol Neurosurg Psychiatry 2002;73:65–7. On page 66, left column, line 9, proline should replace leucine, line 12, protein should replace enzyme; and in table 1, line 8 Del-TFT (63–65) should replace ?TFT (63–65).

We regret that an editing error occurred in the correspondence from Jaster JH, Doohan FC, and O’Brien TF. Demyelination in the brain as a paraneoplastic disorder: candidates include some cases of seminoma and central nervous system lymphoma. J Neurol Neurosurg Psychiatry 2002;73:332. The description of a patient expanded altered, in the first line of the fourth paragraph the text should read “. . .patient who had a non-neurological malignancy, seminoma, and subsequently developed a paraneoplastic syndrome . . .”.

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