The central effects of peripheral injury

Oliver Sacks

I am indebted to Drs Stone, Perthen and Carson for their thoughtful consideration of my book *A Leg to Stand On*, although I do not agree that the experience was a functional or conversion phenomenon. This was, however, my own first thought when I discovered that the leg had gone ‘dead’ on me. I asked to be seen by the psychiatrist at the hospital, and he was struck by the co-occurrence of many factors, but he said that it did not resemble any hysteria he had come across. My surgeon spoke, vaguely, of ‘inhibition’ in the spinal cord, although he agreed that the distribution of sensory and motor loss did not follow any clean neuro-anatomical pattern. I too had observed this—in particular the flaccidity of some of my hip muscles and, in great contrast, the preserved and free movement of my foot, which felt very much part of me, albeit separated from my hip by a senseless, immobile and alienated leg, encased in its long, white cylindrical cast.

One of the orderlies at hospital told me that he had fractured both legs and part of his pelvis in a parachute accident, and had long casts on his legs, both of which seemed to him ‘dead’ or alienated. He gained much reassurance, during these weeks of immobility, from being able to touch his normal-feeling feet together. My friend Jonathan Miller told me that when he had been in medical school (we qualified at much the same time), one of his fellow students allowed himself to be put in a full body cast, an experiment suggested by a neurologist at the hospital. The young man, normally of a somewhat phlegmatic character, panicked when the cast was completed, and said he could no longer feel his body below the neck, he insisted that the cast be taken off. During my hospitalisation, the physiotherapist at the hospital remarked that she wished transparent casts were available to reduce the feeling of alienation.

Whatever the cast may have contributed to this sense of an alien leg was heightened by the damage to the quadriceps and its innervation, both sensory and motor. Recently I had a total knee operation. It was only realised in the late 1970s that it is crucial to get limbs back into action as soon as the requisite surgery and splinting is done. Otherwise, their action-patterns may be (temporarily) lost. When I ruptured the quadriceps of my other leg, in 1984, I was stood up in the recovery room as soon as the spinal anaesthesia wore off. In this instance, there was no alienation or paralysis.

Taking so robust a neurological basis into consideration, there is no need to postulate a dissociative or functional disorder, although, of course, it is possible. I would be the last to deny this, and I think that there may have been elements of functional overlay superimposed on a very real neurological condition, the spinal and cerebral response to an injury involving the integrity and innervation of a major postural muscle like the quadriceps.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

Received 19 March 2012
Accepted 20 March 2012

J Neurol Neurosurg Psychiatry 2012;83:868.
doi:10.1136/jnnp-2012-302801
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*J Neurol Neurosurg Psychiatry* 2012 83: 868
doi: 10.1136/jnnp-2012-302801

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