ing the patient a cerebral biopsy and not altering substantially the prognosis in the case of a tumour, as has previously been suggested by van der Velden *et al* in a similar case.³

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Fig 1A 1st CT scan showing an enhancing lesion in the right frontal area.

Fig 1B CT scan at 6 weeks showing marked regression of the lesion.

Sagar *et al* reply:

We were interested to hear of the case of multiple sclerosis described by Vanneste and Davies, although we have not seen the CT scan pictures. This case, and the one recently reported by Abbott *et al*¹ are similar to the eight cases reported and reviewed by us in showing not only mass effect on their CT scans but also the "cerebral" form of the disease (in these two cases, aphasia and/or seizures).

We agree that increased recognition of these features of multiple sclerosis should reduce the need for diagnostic biopsy particularly in cases with a compatible past history. Attempts to improve the clinical state by treatment with dexamethasone may be reasonable in a very sick patient in whom the differential diagnosis is limited but, as Vanneste and Davies remark, its efficacy in the disease is questionable. In general, it is clearly important to base the investigation and management on the precise clinical and radiological features of each case since these scan appearances may be due to lesions other than glioma or multiple sclerosis and are occasionally caused by infective lesions.^{2,3}

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A case of receptive amusia with prominent timbre perception defect

Sir: Mazzucchi *et al*¹ describe a patient with a right temporal lesion and found that the patient had deficits in recognising the timbre of music and other sounds. These deficits are remarkably similar to disturbances in prosody which also occur with right hemisphere lesions. As Weintrub *et al*¹ (Arch Neurol 1981;**38**:742-4) pointed out prosody "refers to the distribution of stress and melodic contour in speech.

Modulation of prosody can thus be used to impart affective tone, introduce subtle shades of meaning, and vary emphasis in spoken language". In patients with disturbances in prosody secondary to right hemisphere lesions, such deficits as inability to distinguish stress patterns in compound words and inability to discriminate intonations and phonetic stress in sentences were found. It would thus appear that the timbre perception defect described by Mazzucchi *et al* was a particular form of dysprosody.

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Reference

- ¹ Mazzucchi A, Marhini C, Budai R, Parma M. A case of receptive amusia with prominent timbre perception defect. *J Neurol Neurosurg Psychiatry* 1982;**45**:644-7.

Mazzucchi replies:

We thank Dr Procopis for the comments on our paper *A case of receptive amusia with prominent timbre defect*. We would however underline that prosody and timbre correspond unquestionably to different definitions: *prosody*, as reported by Dr Procopis, refers to "distribution of stress and melodic contour in speech", in other terms, prosody is related to a sequence of different sounds in which their *intensity* and *rhythm* vary; *timbre* depends on the harmonic content of the sound, that is it is the peculiar quality of overtones that allows recognition of an instrument or voice as being different from another. Therefore, in *semeiological and descriptive terms*, prosody and timbre must be considered as two distinct concepts and both corresponding disorders may be present in the same patient. If you proceed from the semeiological level to the level of the underlying neural mechanisms, this distinction could be more doubtful. In any case, until now no data exist on the possible relationship between prosody and timbre, just as it is not clear, generally, whether there is a unitary mechanism of sound and musical cognition or, rather, a combination of abilities which are independent of each other.

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