antibodies were, however, present and a labial salivary gland biopsy showed numerous lymphoid aggregates consistent with a diagnosis of the sicca syndrome. The patient subsequently admitted to rather dry eyes, and had moderate caries. A Schirmer's test confirmed poor tear production.

This patient provides another example of an association between the sicca syndrome and inflammatory polyneuropathy, and lends further support to the hypothesis that, like the sicca syndrome and systemic lupus erythematosus with which they are also associated,² the inflammatory polyneuropathies have an auto-immune basis. Our patient developed a clinical neuropathy at a time when symptoms of the sicca syndrome were minimal. This finding illustrates the value of maintaining a high index of clinical suspicion, and of performing a serological auto-antibody screen in patients suspected of having an inflammatory polyneuropathy, but in whom there are no overt features of an associated disease. By this means, associated auto-immune disorders may be uncovered prior to the development of serious manifestations.

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to present with a focal painful epilepsy affecting one half of his scrotal sac.

We told him at the time he should have published it.

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Reference

- 1 Bhaskar PA. Serotal pain with testicular jerking: an unusual manifestation of epilepsy. *J Neurol Neurosurg Psychiatry* 1987;**51**:1233.

Thymoma without myasthenia gravis: electrophysiological study after thymectomy

Sir: Martinez and Jimenez¹ reported a patient with thymoma without clinical evidence of myasthenia gravis, in whom single-fibre EMG (SF-EMG) studies demonstrated abnormal neuromuscular transmission. We had previously reported increased jitter on SF-EMG studies in three patients with thymoma, none of whom had clinical myasthenia gravis.² One patient had a malignant thymoma with red cell aplasia (table, Pt 1) but there was no weakness on examination. Acetylcholine receptor antibody (AChR-Ab) levels were normal and jitter was increased in the extensor digitorum communis (EDC) muscle. After receiving prednisone for treatment of anemia, he developed mild weakness of ocular and shoulder muscles which improved after edrophonium. SF-EMG studies performed on four occasions over a 6 week period demonstrated persistently abnormal neuromuscular transmission (table). He died of infection 2 months after his initial SF-EMG study.

In the second patient (table, Pt 2), a mediastinal mass was discovered on routine chest radiography and a benign, encapsulated thymoma was removed. The patient had no weakness on examination before surgery or six months later. He had had no symptoms of myasthenia gravis 10 years after surgery. AChR-Ab was normal. Jitter was increased in the EDC before surgery and miniature end-plate potential amplitude was decreased in an intercostal muscle biopsy obtained at thymectomy. Jitter was still increased in the EDC three weeks after surgery. Six months after surgery there was a decremental response to stapedial reflex fatigue testing, and this was partially reversed after the administration of edrophonium.³

The third patient (table, Pt 3) was a man who was found to have an anterior mediastinal mass on routine radiography at age 78 years. Retrospective review of previous radiographs revealed that the mass had been present for at least three years, with slowly progressive enlargement. There was no evidence of myasthenia gravis by history or on examination and serum AChR-Ab levels were normal. Jitter was increased in the EDC and there was a decremental response to stapedial reflex testing which did not change after administration of edrophonium.

The clinical manifestations of myasthenia gravis may be subtle and may not be detected unless carefully sought. These patients demonstrate that neuromuscular transmission may be abnormal in patients with thymoma even when clinical examination is normal. We feel that all patients with thymoma should be suspected of having myasthenia gravis and should be evaluated for this possibility before surgery. Since the history, physical examination, AChR-Ab level and repetitive nerve stimulation may all be normal in such patients, increased jitter may be the only evidence of abnormal

Serotal pain with testicular jerking: an unusual manifestation of epilepsy

Sir: I was interested in Dr Bhaskar's description of a man presenting with focal epilepsy in his scrotum.¹ I am afraid it has been described before, but only to the students and junior staff of Dr Michael Kremer. Dr Kremer is at present unable to relate the story himself, but he described a man whom he saw during the 1939-45 war who had a bullet wound to the brain. Bullets in those days created damage only between entry and exit wounds, and he survived the experience

Table Details of patients

		SF-EMG in EDC				
Patient	Diagnosis (Normal value)	Date	Mean MCD (μ Sec) (< 34)	% Fibre pairs with		AChR-Ab (nMoles) (< 0.1)
				Blocking	Normal jitter (> 90%)	
1.	Malignant thymoma, red cell aplasia	10/ 7/76	43	11%	83%	0.016
		10/28/76	41	5%	64%	
		11/ 1/76	38	0	95%	
		11/23/76	64	24%	68%	
2.	Benign thymoma	7/13/77	49	12%	76%	0
		7/21/77	46	9%	70%	
		8/ 8/77	44	0	77%	
3.	Probable thymoma	5/13/78	43	0	91%	0