Book reviews


Fifty years ago when the American Neurological Association published a semi-centennial volume recording the history of the ANA and its founders, neurology and psychiatry were natural partners (surprisingly, a popular alternative seems to have been medical jurisprudence). In 1975, the centennial anniversary of the ANA, the scene is transformed and this volume is a fascinating account of the change. It was the rapid advance of psychiatry as a specialty which led to the separation of practice. The advance of neurology came later and was delayed in many areas by the claims of neurosurgery. Appropriately, the Presidents of the ANA in the last two years of its first 50 years were Adolf Meyer and Harvey Cushing. Ancestor worship is obviously not an exclusively British trait, but none will deny the importance of recording facts and impressions of pioneer neurologists before memories fade. If this necessitates, in equity, recording of some trivia and of minor figures it is nonetheless obvious that American neurology has had more great names than has been recognized in Europe, and most of them have been President of the ANA. For some few it is sufficient that they travelled in Europe, but the modern young European is proud to claim ‘been to America’ in his c.v. and not least for neurology.

A regional history of neurology in N. America shows how centres of excellence (including the best in the world) grew from the efforts of a few enthusiasts with more or less reluctant independence from psychiatry or internal medicine. But clearly there are vast areas of that enormous country without modern neurology. They are shrinking fast because of the many excellent training programmes of recent years. There are interesting accounts of the role of government in neurological research and development through the Veterans Administration, the National Institutes of Neurological Diseases and Blindness, and the Armed Forces. It is particularly instructive to review the part played by voluntary organizations in stimulating government to develop the National Institutes which became the mainspring of the training and research programmes, giving to them a recognizable American stamp. Though some mistakes were made, there is surely a lesson here for British neurology.

A century is a long time to achieve maturity, but without question neurology is now well established as an active clinical and academic discipline in America. This review is an opportunity to convey to American neurologists the congratulations and admiration of their European colleagues and wish for second-sight to read the centennial volume.

J. A. SIMPSON

Letter

TRIGEMINAL NEUROPATHY WITH NASAL ULCERATION

SIR,—The most interesting paper by Spillane and Urich (1976), which presents the neuropathological findings in their patients with trigeminal neuropathy who have developed nasal ulceration, is certain to focus attention on the aetiology and pathogenesis of this condition.

Ulcération en arc of the face and nose was first described in 1933 by McKenzie in Canada and Loveman in the United States. In 1959, Spillane and Wells presented a comprehensive review of the literature and reported this finding in 25 patients, including one of their own, after root section of the trigeminal nerve, or the injection of alcohol into the Gasserian ganglion for the relief of trigeminal neuralgia. They also presented clinical details of 16 patients with isolated trigeminal neuropathy and described progressive ulceration of the nose in one patient with this condition.

In recent years, there has been much discussion and controversy concerning the precise nature of these ulcerative lesions of the face and nostril. In 1967, Henderson noted that ulceration of the face and nostril was reported in 12 (18%) of 66 patients who had developed permanent anaesthesia of the cheek and nostril after the injection of alcohol into the Gasserian ganglion. Henderson stated that these ulcers usually appeared on the alar margin of the nostril from one to six months after this surgical procedure, and, though he stated that the precise cause was uncertain, he supported my earlier contention that self-inflicted trauma in response to paraesthesiae may be of importance. I had postulated that ulceration of the face with erosion of the ala nasi after the injection of alcohol into the Gasserian ganglion, sensory root section of the trigeminal nerve, and in other patients with interruption of the peripheral or central sensory pathways of the trigeminal nerves were self-induced (Freeman, 1966).
I have also seen quite a few patients who have developed ulceration of the skin of the forehead and scalp after herpes zoster and suggested that these so-called trophic lesions involving the analgesic skin may be more often seen by our dermatological colleagues than by neurologists and neurosurgeons, and that their true incidence is far greater than the paucity of reports in the neurological literature would suggest (Freeman, 1967).

I have also reported clinical details of two patients with acute vascular disorders of the brain stem who later developed progressive ulceration of the skin of the face with cartilaginous destruction of the nostril. The neurological findings in these two patients indicated that the central sensory connexions of the trigeminus in the spinal tract and nucleus would be involved. In each patient there was dissociated anaesthesia, with loss of pain and temperature sensation but preservation of light touch, over the ipsilateral cheek and nostril and, in one patient, ulceration of the skin had developed above the eyebrow as well (Figure).

Each patient informed us that, after their acute vascular episode involving the brain stem, there had occurred persistent pain and intense and unpleasant irritation on the affected side of the face where this dissociated anaesthesia was found on neurological examination. The pain was described in such terms as a 'deep gnawing burning pain as if the whole of one side of the face was on fire' and the persistent and intense irritation was likened to 'something crawling under the skin and inside the face' or to the 'face being invaded by ants'. We were further informed that this paraesthesia was so distressing and unbearable that our patients found themselves picking at this analgesic area of the face and nostril with their finger-nails and readily admitted scratching off pieces of skin and tissue, and often woke up in the night to find themselves doing this involuntarily. We were, in fact, able to confirm these statements by careful observation in hospital.

Critical appraisal of our own cases as well as those reported in the literature led me to the belief that the development and later progression of ulcerative lesions of the face and nostril were not, as hitherto presumed, trophic in origin (by definition pertaining to nutrition), but were self-inflicted and could thus be preventable.

My thesis was that these destructive lesions with excoriation of the skin of the face and erosion of the ala nasi were the direct result of repeated trauma by the finger-nails to those parts of the face and nostril which had been rendered analgesic through involvement of the peripheral or central sensory pathways of the trigeminal nerve, being provoked by this persistent and painful paraesthesia.

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REFERENCES


