Letters


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Smoking and dementia of Alzheimer type

Sir: Several surveys have reported a negative association between smoking habits and Parkinson's disease suggesting that smoking may decrease an individual's risk of developing the condition.1 An observation made by Appel,2 that only six of 30 Alzheimer patients in his study had smoked at any time in their lives, led him to conclude that a similar effect may operate in dementia of Alzheimer type (DAT). This is of interest in view of the recently demonstrated loss of nicotinic receptors in the cerebral cortex of DAT patients.

Conversely, Shalat3 has presented data from a case control study, showing that Alzheimer patients were more than twice as likely to be smokers or ex-smokers than were controls. Furthermore, an increased risk of the disease was positively correlated with level of cigarette consumption.

Our data refer to patients attending the Maudsley Memory Clinic and the psychoanergetic unit of the Royal Bethlem and Maudsley Hospitals. The medical notes of 81 persons over the age of 65 with a diagnosis of “probable” dementia of Alzheimer type were reviewed to obtain information about smoking habits. Where such information was not recorded the next of kin were contacted by telephone. One hundred and twelve persons from a local luncheon club and care home were selected as age-matched controls and interviewed.

Seventy one per cent of male DAT patients and 32% of female DAT patients either smoked or gave a history of having smoked, as compared with 77% of male controls and 44% of female controls. Even allowing for sex differences (with the use of an appropriate log-linear model) no significant difference in the lifetime prevalence of smoking between the two groups was found (chi² = 1.23, p = 0.75, Odd's ratio = 1.58).

Our results do not support either study referred to above but are in accord with the findings of an epidemiological study of patients developing the disease before the age of 70.9

Clearly further studies are required to elucidate this question but can only be conducted if past and present smoking behaviour is perceived as an important variable and therefore accurately recorded in medical notes.

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References


6 Shalat S. Personal communication.


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Listeria monocytogenes infection with rhombencephalitis

Sir: Listeria monocytogenes meningitis is not uncommon,1 2 but rhombencephalitis as a complication is rare, only six cases being reported in the English literature.3 – 8 We describe a further case which draws attention to impaired central control of respiratory movement during the acute illness and to the development of new brain stem lesions long after the disappearance of active infection.

A previously healthy 43 year old Cau- casian male presented with nausea, abdominal pain and headache of 4 days' duration. Increasing unsteadiness of gait, slurring of speech and difficulty swallowing had been present for two days. On the day of admission he developed perioral numbness and left facial weakness. The temperature was 38°C, pulse 100 bpm and blood pressure 150/90 mm Hg. He was alert and orientated. The neck was supple. There was evidence for multifocal bilateral brainstem disease with dysarthria, right ptosis, pupillary asymmetry, left conjugate gaze paresis, left facial paralysis of lower motor neuron type, and left weakness of the left palate and right side of the tongue. Pinprick and temperature sensa-
tion were impaired in a muzzle distribution extending down the right side from the face to the T11 dermatome. There was dysmetria of the left arm and leg and gross truncal and gait ataxia.

A contrast enhanced CT brain scan and chest radiograph were normal. Cerebrospinal fluid (CSF) contained 12% mononuclear (56% polymorphonuclear cells, 38% lymphocytes, 6% monocytes), the protein was 0.76 g/l, and glucose 5.5 mmol/l. No organisms were present in the stained film or grew on culture.

He received intravenous fluids, ampicillin, cloxacillin and tobramycin. Five hours after admission, while awake, there was a rapid decrease in respiratory effort and he became cyanosed. He could take deep breaths on command but during a prolonged apnoeic episode a tonic-clonic seizure occurred. After recovery of consciousness automatic respiratory movement did not return and intermittent positive pressure ventilation (IPPV) was begun. On the following day Listeria monocytogenes was isolated from the blood cultures. Ampicillin and tobramycin were continued for four weeks.

The systemic evidence for infection settled over the first two days but there was further neurological deterioration with the develop-

ovement of complete right ptosis, right facial weakness, severe weakness of jaw opening and closure, paralysis of tongue protrusion.