Aphemia as a first symptom of multiple sclerosis

SIR: I must take exception to the diagnosis of multiple sclerosis given the patient described by Herderschee et al in the J Neurol Neurosurg Psychiatry.

The history and findings do not fulfill the Poser et al criteria for laboratory supported definite multiple sclerosis for the important reason that dissemination in time, as well as dissemination in space, is not present. All the parameters cited in support of the diagnosis of multiple sclerosis, that is the CSF findings, the CT and MR images and, of course, the resolution of symptoms are all compatible with acute disseminated encephalomyelitis, a diagnosis which on the basis of the information provided seems considerably more likely.

This is, unfortunately, a common and distressing problem in differential diagnosis, compounded by the still not widely known fact that all the ancillary supporting data, viz the elevated CSF IgG, the presence of oligoclonal bands in the CSF, peri-ventricular areas of attenuation with or without contrast enhancement, and areas of increased signal intensity by MR, can be seen equally in acute disseminated encephalomyelitis as in multiple sclerosis.

CHARLES M POSER
Department of Neurology, Harvard Medical School, Beth Israel Hospital, 330 Brookline Avenue, Boston, Mass 02215, USA

Palatal myoclonus influenced by neck posture

Sir: We read with great interest the communication on palatal myoclonus influenced by neck posture.1 Jacobs et al2 had previously reported two cases of palatal myoclonus, one of which varied with neck posture and the other the myoclonus disappeared after two years. We report a patient with posture-related palatal myoclonus who remained after three months.

A 52-year-old man presented with a three-month history of a clicking noise emanating from his throat, occurring only in certain neck postures. He had no problems with hearing or swallowing. On examining his throat with his neck flexed anteriorly and to the right, a clicking noise appeared associated with rhythmic contractions of the throat. The palatal myoclonus disappeared with his head in the midline position. It failed to appear in any other neck posture. His CT scan showed mild frontal atrophy. Three months later, his palatal myoclonus had remitted. Various manoeuvres including breath holding, squeezing the hands, curling the toes, moving joints and hyperventilation are known to exacerbate palatal myoclonus. However, reports of precipitation by certain head and neck movements are rare, our case being the third, and the first in which the myoclonus eventually disappeared. Palatal myoclonus is always associated with a disturbance of the Guillain Mollaret triangle with subsequent olivary hypertrophy.3 The

References

M MELO PIRES
B NUNES
L MONTEIRO
Servico de Neurologia
Hospital Geral de Santa António
4000 Porto
Portugal

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