Matters arising

neuromuscular transmission. Our experience, like that of Martinez and Jimenez, indicates that these patients may never demonstrate clinical manifestations of myasthenia gravis, thus therapeutic decisions should be made based on the clinical findings, rather than EMG abnormalities.

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essential tremor and, as implied by Corbin and Williams, other disorders of movement.^{2 8}

Co-occurring impairment of one or more of the other components of motor speech, namely articulation, respiration, and prosody (speech rhythm) is consistent with dysarthria rather than a focal laryngeal disorder.^{2 7-9}

The response of spastic dysphonia to treatment seems to depend upon aetiology, type of disorder (adductor, abductor, mixed), and mode of therapy.^{4 7}

For those types of spastic dysphonia for which a recognisable aetiology cannot be identified, the term "idiopathic spastic dysphonia" has been recommended along with regular follow-up, which may eventually reveal an underlying substrate for the disorder.²⁻⁴

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Stridor during dystonia phases of Parkinson's disease

Sir: Doctors Corbin and Williams' report of respiratory stridor co-occurring with limb and orofacial dystonia in two patients with idiopathic Parkinson's disease is noteworthy.¹ However, their statement that "... spasmodic dysphonia is now recognised as being a form of focal dystonia of the laryngeal muscles" (p. 821) needs clarification.

The cardinal signs of spastic (spasmodic) dysphonia, principally (1) intermittent or regular adductor voice arrests secondary to vocal fold/laryngeal hyperadduction, (2) moments of strained, effortful vocal quality interspersed within apparent normal phonation, and (3) intermittent or regular breathy moments secondary to abductor glottal arrests may represent psychogenicity,

References

- 1 Corbin DOC, Williams HC. Stridor during dystonic phases of Parkinson's disease. *J Neurol Neurosurg Psychiatry* 1987;**50**:821.
- 2 Aronson AE. *Clinical Voice Disorders*. 2nd ed. New York: Thieme Inc, 1985.
- 3 Hartman DE, Abbs JH. Clinical investigations of adductor spastic dysphonia. *Ann Otol Rhinol Laryngol* (in press).
- 4 Aronson AE, Hartman DE. Adductor spastic dysphonia as a sign of essential (voice) tremor. *J Speech Hear Disord* 1981;**46**:52-8.

- 5 Hartman DE, Aronson AE. Clinical investigations of intermittent breathy dysphonia. *J Speech Hear Disord* 1981;**46**:428-32.
- 6 Marsden CD, Sheehy MP. Spastic dysphonia, Meige disease, and torsion dystonia. *Neurology* 1982;**32**:1202-3.
- 7 Hartman DE, Abbs JH. The Dysarthrias of Movement Disorders. In: Jankovic J, Tolsa E, eds. *Facial Dyskinesias: Advances in Neurology*. New York: Raven Press (in press).
- 8 Hartman DE. Neurogenic dysphonia. *Ann Otol Rhinol Laryngol* 1984;**93**:57-64.
- 9 Darley FL, Aronson AE, Brown JR. *Motor Speech Disorders*. Philadelphia: WB Saunders, 1975.

Corbin and Williams reply:

Sir: Dr Hartman reminds us of the possible mechanisms of vocal cord dysfunction in spasmodic dysphonia; however, in our final paragraph¹ we sought to emphasise the need for clinicians to consider dystonia as a cause of what may otherwise be an enigmatic disorder; we refer not only to some cases of spasmodic dysphonia but also to problems such as piano-player's dystonia and the occupational dystonias.² Many such cases were previously classified as hysterical. Dr Hartman's policy of accepting that some cases of spasmodic dysphonia lack recognisable aetiology is safer in that it does not deny the possible existence of an organic cause.

References

- 1 Corbin DOC, Williams AC. Stridor during dystonic phases of Parkinson's disease. *J Neurol Neurosurg Psychiatry* 1987;**50**:821-2.
- 2 Lees AJ. *Tics and Related Disorders*. London: Churchill Livingstone, 1985:166.

Book reviews

Neurological Disorders. (*Treatment in Clinical Medicine series.*) By D Parkes, P Jenner, D Rushton, C David Marsden. (Pp 227; £38.00.) London: Springer-Verlag, 1987.

This is the fifth monograph in a series on management and treatment in specialities in medicine and serves as a perfect riposte to those who would believe that the neurologist has a major role in diagnosis but only a minor role in therapy. It contains a practical approach to major neurological disorders which is spiced by the pharmacological expertise of Dr Jenner in explaining not only

when, but why, a particular agent should be prescribed.

The initial chapter is a review of the actions of drugs on the nervous system and briefly considers the role of the blood brain barrier. It contains useful tables of drugs which are agonists and antagonists for the various neuro-transmitter receptors and examples of compounds which act upon specific receptor sub-types. There follow chapters on each of the common neurological disorders with the appropriate therapy and, where known, a summary of their mode of action. The authors' own interest and expertise in the treatment of movement disorders and sleep disorders is apparent in these, the best, chapters in the book and the whole provides a useful practical guide to logical therapy in neurological

disorders. Inevitably the particular biases of the authors are revealed and not everyone will agree with their suggestion that steroids have a role in ischaemic stroke. Indeed the authors seem somewhat uncertain themselves in that on one page they state "it may therefore be beneficial to treat focal oedema around an infarct using osmotic diuretics or steroids" and on the next page "post-infarction oedema does not respond to steroids".

In the chapter on infections it would have been useful to have a suggestion as to the most reasonable combination therapy in the infant, adult or aged patient presenting with a presumed but unidentified or partially treated bacterial meningitis rather than the bald statement that therapy "depends on isolation of the causative organism". No