Autoscopy in hemianopic field

Autoscopy is the visual perception of oneself or part of one's body into the external visual space. Although this is the conventional definition, autoscopy phenomena need not always be visual, nor need it be perceived in front of the viewer. It has been described in normal subjects, in organic neurological, functional (migraine, epilepsy) and psychiatric disorders. Autoscopy in focal cerebral lesions is the rarest. When hemianopic and autoscopic images appearing in the hemianopic field are still rarer. Our case had a right occipital infarct with autoscopy in the left hemianopic field.

A sixty year old male was admitted with a history of bifrontal throbbing headache which started suddenly two weeks before. About one week after the onset, the headache became more severe and almost simultaneously the patient started seeing his own image in front of him on the left side. Five days later, at the time of admission he was able to give a detailed account of his experience. The image first appeared about 30 cm in front of him, more towards the left, and persisted for three to four minutes. He could identify the face and upper part of the body including the clothes and objects of daily use. It was a disturbance of body schema affecting the shape, size and mass of the body and its parts. The concept of body schema is not an instinct. As a child grows, there is creation of a tridimensional model of the body and its surrounding space. External and internal stimuli contribute to the creation of this model which is dynamic and fluctuates according to circumstances. In addition to the organ parts, certain other attributes are also represented in this model, such as, ego or possessiveness. The conventional body image is not confined to the physical body alone but includes the clothes and objects of daily use. It is a disturbance of body schema affecting the shape. Autoscopy experience involving senses other than vision have been described in which autoscopy is accompanied by tactile and auditory characteristics. The image involves the whole body or part of it, but it always includes the face. It may be transparent, opaque or coloured and may show expressions. Autoscopy may be associated with infec-

tions and intoxications, especially chronic alcoholism and typhoid fever; psychoses; epilepsy; migraine, and diffuse and focal cerebral lesions.

There is no satisfactory explanation for this phenomenon. But it is likely that autoscopy is due to abnormalities in a high level system which is responsible for the representation of the body in its environment. Abnormal functioning of this system may result in misinterpretation of the body in space. Although autoscopy does not have any localising value, it may be an early manifestation of a focal cerebral disease.

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Reoperation related to graft complica-
tion following anterior cervical fusion

At our department anterior cervical decom-
pression and fusion is usually performed using the Cloward or the Smith Robinson method; for this we use a cervical spine spica, and occasionally employ the technique of partial multiple vertebrectomy with the insertion of a block graft, a procedure we refer to as a “Trench”. It is our standard practice to obtain a lateral cervical spine radiograph on the first postoperative day. Some surgeons find the radiograph useful to confirm that the correct level has been fused. In addition, the radiograph will provide some information about the degree of retroparlumpathy resulting due to haematotha. However, we interpret the significance of postoperative cervical radiographs in conjunction with the clinical findings. If the patient is symptomatic and the radiograph shows a graft abnormality an early re-exploration may be undertaken. In an asymptomatic patient, partial anterior slippage of the graft or minor degree of collapse are considered acceptable and the patient is followed up. If the patient develops symptoms or signs then a late re-exploration may be performed.

Between 1979-89, 822 patients had anterior cervical decompression and fusion at our department. Fifty one of these had further anterior decompression, 27 at a different level and 24 at the previously operated level. In 12 of the latter group, re-exploration was related to concern over fusion of the bone graft. The other 12 patients had a re-exploration to remove retained osteophytes or disc fragments. Other patients not counted in this group included one who was re-explored for infection following a cervical discectomy without a fusion and three who had reoperation to evacuate a postoperative haematoma in the neck. Preoperative radiographs were carried out in all cases to identify the correct level before and therefore none of our patients had a fusion at the wrong level. We carried out a retrospective study of the 12 patients that required re-exploration because of a graft complication. The postoperative clinical features and the early check cervical spine radiograph were analysed to find out if the clinical features alone are a reliable predictor of the patients with a graft complication that may require re-exploration. In this group of patients four had a one level Cloward operation, two had a two level Cloward operation, three had one level Smith Robinson procedure, two had a three level “Trench” procedure and one had a four level “Trench” procedure. The graft had collapsed in six cases, slipped anteriorly in five and slipped posteriorly in one case. The early check radiographs showed a serious abnormality which necess-
itated an urgent re-exploration in four cases, each of whom was symptomatic at the time of surgery. In four other cases, the early radiograph showed a minor abnormality which was initially managed conservatively. Re-
exploration was performed between two and four months postoperatively when the comp-
lication worsened radiologically and was accompanied by symptoms and signs. The final four cases had a satisfactory early check radiograph and the complication became obvious between one week to five months later. They all had clinical symptoms that prompted us to repeat the radiographs.

It was clear that each of the 12 patients had an obvious clinical reason for the time of re-
exploration whether it was early or late. These were: severe brachialgia affecting the asymptomatic side in two cases, severe dysphagia in four cases, recurrence and/or worsermy of myelopathy on four cases and recurrence of brachialgia in one case. In one other case there was no postoperative im-
provement and the patient’s myelopathy slowly deteriorated. In our study we did not encounter a similar case that was re-explored on the basis of a graft abnormality on the plain cervical radiograph alone.

Our rate of reoperation related to a graft complication following anterior cervical fusion was 1-45%. It is most likely that of the 822 patients that had anterior cervical fusion at our unit, a number of them had a minor degree of graft abnormality on the post-
operative radiograph that were managed conservatively and did not develop symptoms and signs to necessitate a reoperation. Luns-
ford3 reported a reoperation rate of 4% follow-
ning anterior cervical discectomy and fusion and this reoperation rate reported by Williams1 was 5-1%.

In our experience a significant graft abnor-
mality that necessitated a reoperation was always associated with a definite clinical problem. Abnormalities on the cervical spine radiographs in asymptomatic patient could be managed conservatively.4 It is possible therefore to conclude that an early radiograph after a cervical fusion is unnecessary in a patient who is asymptomatic and improving. A radiograph is needed only if the patient complains of dysphagia, persistence or wors-
ening of their radiculopathy or myelopathy. Late recurrence of symptoms or signs is an indication for further radiographs to assess the condition of the bone graft.

While we acknowledge that there are many reasons for an early postoperative radiograph, we do not feel that these reasons are suffi-
ciently convincing in an asymptomatic patient. A patient who had a wrong level fused will continue to have symptoms. An experienced spinal surgeon will know the adequacy of the fusion at the end of the operation and is thus able to select the high risk asymptomatic patients who need to be carefully followed up with postoperative radiographs. This decision will take into account the pathology (for example, rheu-
matoid arthritis), the preoperative assessment (for example, cervical instability) and the technical aspect of the operation (for exam-
ple, osteophyte formation, bone graft and unsat-
factory positioning).

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MATTERS ARISING

Akathisia following traumatic brain injury

Akathisia following traumatic brain injury involving right parietooccipital and orbitofrontal areas may be due to blockade of dopamine1 lateralised to the right hemisphere.2 Fluox-
etine-induced akathisia in patients with obes-
sive-compulsive disorder3 whose right hemi-
sphere is at a higher metabolic rate4 suggests that inhibition of dopamine, which is mediated by serotonin in obsessive-compulsive disor-
ders, may occur as a result of post-
traumatic alteration of metabolism in the right hemisphere. This lends further support to the role of decreased dopaminergic activity in the prefrontal cortex in akathisia.5

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4 Baxter LR, Schwartz JM, Mazziotta JC, et al: Cerebral glucose metabolic rates in non-

Isolated palsy of the fourth cranial nerve caused by an intracavernous aneurysm

An interesting case of isolated trochlear palsy due to an intracavernous aneurysm was recently reported by Maurice-Williams and Harvey.1 Two points of contention arise in this report: 1) the need for performing carotid angiography early in the course in an elderly patient with an isolated fourth nerve palsy, and 2) has a cause and effect relationship between intracavernous aneurysm and fourth nerve palsy been conclusively shown in this case?

As they acknowledge in their report, isolated trochlear palsy are most commonly caused by trauma and vascular disease.2 In patients over the age of 50 years, an ischaemic...