Maffulli replies:
Dr Lederman has every reason to be puzzled that the symptoms described referred to the left forearm, as indeed the forearm kept in pronation in a violinist is the right. We apologise for the error, but the description of the possible mechanisms made it quite clear that we were considering the right forearm.

We agree that the diagnosis of posterior interosseous neuropathy is often difficult, due to the paucity of definite signs. Nevertheless, in our opinion, the patients described were indeed showing a transitory deficit of the posterior interosseous nerve, and such a diagnosis was thus justified.

NICOLA MAFFULLI
FRANCESCO MAFFULLI

Clonazepam for palatal myoclonus
We were pleased to learn Drs Bakheit and Behan1 found clonazepam a successful remedy for palatal myoclonus, as such an outcome extends our observation reported in 1977.2

The patient we described, a 68 year old woman, had an inflammatory central nervous system disorder of unspecified type and required, with the passage of time, increasing dosages of clonazepam up to 22 mg daily for optimal symptom control. It would be interesting to know which of the several morbid processes recounted by the authors as being responsible for palatal myoclonus applied in their own case. Likewise, whether suppressive effects were indeed sustained on a dosage of 1-5 mg daily.

RF GLEDHILL

Behan replies:
We have recently been able to study yet another case of palatal myoclonus which was successfully treated by clonazepam. In this, as in the case we reported, the aetiology would appear to be idiopathic, progressive degeneration of the central tegmental tract.

PETER O BEHAN

Transient hypoglossal nerve palsy and Horner's syndrome: carotic dissection
Drs Saito and Onuma reported the case of a woman with sudden onset of left sided headache and Horner's syndrome (post-ganglionic); three days later she also developed a left hypoglossal nerve palsy, but in the course of two months all these features resolved.1 The cause could not be established, but it probably would have been if a carotid instead of a vertebral angiogram had been performed. Carotid dissection is usually associated with ipsilateral headache or neck pain,2,4 and sometimes with Horner's syndrome,3 hemifacial paralysis,1 or both.4

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Saito replies:
I am grateful for the interest and pertinent comments of Drs Van Giijn and Koudstaal on our case report. In fact, the hypoglossal nerve may be compressed by the internal carotid artery1 itself or aneurysms arising from it.2 In our patient, contrast enhanced brain CT's, 5 mm in thickness to C-2 level, revealed round or oval lumens of the internal carotid artery and jugular vein to be well-circumscribed and symmetrical on both sides. However, the possibility of carotid dissection cannot be ruled out.

H SAITO

A case of progressive encephalomyelitis with rigidity and positive antilgamic acid dehydrogenase antibodies
The above article was published this year in the May issue of the journal (pages 449–51). Since publication, I have received a communication from Dr. P. De Carli of the University of Zurich, who correctly points out that the title is incorrect. The word dehydrogenase should read deacetylase, as in glutamic acid deacetylase.

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A predominantly cervical form of spinal muscular atrophy
I read with interest the paper by Goutieres et al on the cervical form of spinal muscular atrophy.1 Spinal muscular atrophy is the commonest neuromuscular disease affecting black children in South Africa. The clinical findings in this group of children are similar to those reported from Europe, Asia and America except in two aspects, that is, a paucity of a positive family history (only 9%) and the frequent involvement (80%) of facial muscles in the severe infantile form of the disease.2 Goutieres et al mention that they were not able to find cases of the cervical form of spinal muscular atrophy in the literature. We have seen three black children (two previously documented) with this form of the disease in the last 10 years. All three patients presented with poor head control and an exclusive involvement of the upper limbs with both proximal and distal weakness. The lower limbs were normal in all three cases; reflexes were normal in two and brisk in one, whereas they were absent in the upper limbs of all three patients. The face was spared in all and fasciculation of the tongue was present in only one. The small muscles of the hands were wasted in all three patients and there was unilateral deviation and flexion of the wrist with contractures of the long finger flexors in one patient.

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BOOK REVIEWS

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Neurological Aspects of Epilepsy

Surgery for the relief of focal seizures need no longer be an exclusive method for a select group of patients. It is, however, a complicated procedure and requires the establishment of centres with a multidisciplinary team of specialists. Unfortunately in many countries interest in this problem has been very low.

This book has been compiled as an effort to stimulate neurosurgeons interest. It is based on a recent symposium about the neurological aspects of the treatment of epilepsy, a field which has previously been dominated by American epileptologists and surgeons. The participants were, however, exclusively European, who shared experiences to help advance new ideas and methodologies.

The most important and controversial issues not only in epilepsy surgery but in the general treatment of intractable seizures are discussed, although sometimes rather abbreviated. This review provides the essentials of most of the controversies and problems in treating severe epilepsy.

Unfortunately there is little new information presented in this book. Most articles are