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 Behan[1] 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 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 myoclonous applied in their own case. Likewise, whether suppressive effects were indeed sustained on a dosage of 1·5 mg daily.

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1 Bakheit AMO, Behan PO. Palatal myoclonus successfully treated with clonazepam. *J Neurol Neurosurg Psychiatry* 1990;53:806.
2 Gledhill RF, Wiles CM. Cloazepam and bronchial myoclonus. *Ann Neurol* 1977;1:306.

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: carotid dissection

Drs Saito and Onuma reported the case of a woman with sudden onset of left sided headache and Horner's syndrome (postganglionic); 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,[2] hemilingual paralysis,[3] or both.[4]

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1 Saito H, Onuma T. Isolated hypoglossal nerve palsy and Horner's syndrome with benign course. *J Neurol Neurosurg Psychiatry* 1991;54:282–3.
2 Mokri B, Sundt TM, Houser OW. Spontaneous internal carotid dissection, hemicrania, and Horner's syndrome. *Arch Neurol* 1979;36:677–80.
3 Goodman JM, Zink WL, Cooper DF. Hemilingual paralysis caused by spontaneous carotid artery dissection. *Arch Neurol* 1983;40:653–4.
4 Vanneste JAL, Davies G. Spontaneous dissection of the cervical internal carotid artery. *Clin Neurol Neurosurg* 1984;86:307–14.

Saito replies:
I am grateful for the interest and pertinent comments of Drs Van Gijn and Koudstaal on our case report. In fact, the hypoglossal nerve may be compressed by the internal carotid artery[1] itself or aneurysms arising from it.[2] In our patient, contrast enhanced brain CTs, 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

1 Olivier A, Scotti G, Melançon D. Vascular entrapment of the hypoglossal nerve in the neck. Case report. *J Neurosurg* 1977;47:472–5.
2 Endo M, Ohara Y, Saito H, Takase Y, Ooba M. A case of Villaret syndrome by traumatic aneurysm of the internal carotid artery. *Clin Neurol* (Japanese) 1982;18:48–50.

A case of progressive encephalomyelitis with rigidity and positive antiglutamic 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 Camilli, of Yale University, who correctly points out that the title is incorrect. The word dehydrogenase should read decarboxylase, as in glutamic acid decarboxylase.

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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 case. The small muscles of the hand were wasted in all three patients and there was ulnar deviation and flexion of the wrist with contractures of the long finger flexors in one patient.

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1 Goutieres F, Bogicevic D, Aicardi J. A predominantly cervical form of spinal muscular atrophy. *J Neurol Neurosurg Psychiatry* 1991;54:223–5.
2 Moosa A, Dawood A. Spinal muscular atrophy in African children. *Neuropediatrics* 1990;21:27–31.

BOOK REVIEWS

All titles reviewed here are available from the BMJ Bookshop, PO Box 295, London WC1H 9TE. Prices include postage in the United Kingdom and for members of the British Forces Overseas, but overseas customers should add £2 per item for postage and packing. Payment can be made by cheque in sterling drawn on a United Kingdom bank, or by credit card (Mastercard, Visa or American Express) stating card number, expiratory date, and your full name.

Neurosurgical Aspects of Epilepsy.
Proceedings of the 4th Advanced Seminar in Neurosurgical Research of the European Assoc of Neurosurgical Societies. Edited by JD PICKARD, G MAIRA, CE POLKEY AND T TROJANOWSKI. (Pp 144, Price: DM 160; Subscribers to "Acta Neurochirurgica" DM 144). Wien: Springer-Verlag, 1990. ISBN 3 211 82227 5.

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 neurosurgical 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 newer 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