All these variables except number 3 determine the amount and rate of transfer of energy through the skin to the thermal receptors. The standardisation of this energy transfer is a basic prerequisite for techniques of thermal threshold measurement. Their failure to control these variables invalidates any conclusions on the reliability or otherwise of a single component, namely the psychophysical aspect, of the techniques.

In addition to the technical difficulty the authors choose a test that further compounds the problem. In diabetic patients thermal thresholds and other parameters of nerve function vary with blood glucose levels, indicating a non-constant variable.

Their definition of "static" and "dynamic" methods of application of thermal stimulation is misconceived; dynamic stimuli are applied in both techniques (for example, in the Sensortek method, the temperature of the thermal receptors will alter with time when a thermode of different temperature is applied to the skin surface). The authors' statement, in the discussion, that differences between these two techniques are due to the nature of the stimulus (static versus dynamic) has no conceptual or rational basis.

In conclusion, the authors have not assessed the merit of the two psychophysical procedures, rather they have compared two techniques for thermal threshold testing, which incorporate among many other variables, two different psychophysical procedures. The conclusion as to the efficiency or otherwise of the psychophysical aspect of the two techniques is invalid.

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Leyt et al reply: Dr Jamal and his colleagues argue that we are unable to comment on the relative advantages of the two algorithms used for testing thermal sensation as we did not control for a number of confounding variables. Influence of the rate of heat transfer through skin. This was not the aim of our study; we set out to compare, in a routine clinical setting, two technically available methods. The algorithms used were one of many differences between the two methods. We simply made the point that in screening studies the choice of a suitable apparatus need not be determined by the psychophysical basis of the test, this is evident from the similar coefficients of variation of all comparable methods.

Dr Jamal's long excursus into the factors influencing transfer of thermal energy is irrelevant since control of stimulus-related factors other than skin temperature and site would have materially altered the methods from those which are commercially available, and does not support our proposition that precision and reproducibility are related neither to the choice of apparatus nor to the algorithm used. It is our contention that the high variability of all clinical psychophysical methods owes more to "central" processing than to the standardised presentation of the stimulus. Our experience with the Glasgow thermal testing method (as used in the Medelec instrument) showed that it was no more reproducible than the other methods. Further, the finding is which is at variance with Dr Jamal's claim of "negligible" intrindividual variability.

Some of the technical points raised by Dr Jamal apply equally to both methods, so we are unclear how they would affect a comparative study (for example, the surface skin temperature, the lack of calibration of heat transfer at the thermode, the thermode application pressure, and the fact that both methods involve application of uncontrolled tactile stimuli). As to the question of thermal neutrality, Kensualo found that it could be achieved over a wide range of temperatures, 29-37°C; Dr Jamal's advocacy of the use of a basal temperature of 35°C is therefore arbitrary and in addition quite impractical and time-consuming to achieve in diabetic patients, many of whom have peripheral small- and large-vessel disease. The criticism of our use of diabetic patients on the basis of the known effects of ambient blood glucose levels on nerve function is misplaced in an paper devoted specifically to a clinical study of diabetic patients. In addition, in a large group comparison, the effects of blood glucose variation can also be discounted.

A study comparing algorithms alone with control of all stimulus-related factors has yet to be done and remains a formidable challenge. We are yet to be convinced that strict attention to details of presentation of the thermal stimulus is relevant to the testing of thermal sensation in untrained subjects in clinical settings.

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Responses to temperature in primary hypothyroidism

Using standard neurophysiological criteria Beghi et al made a definite diagnosis of polynoephropathy in 72% of 39 consecutive outpatients with primary hypothyroidism. They took care to maintain the temperature at 32-34°C throughout these studies, but do not comment upon core temperatures.

It is well recognised that hypothyroid patients may be hypothermic.1 In 1983 we found similar abnormalities in peripheral nerve conduction in hypothyroid patients.2 We also corrected skin temperature in these studies. Central conduction velocity in the visual pathways, represented by latency of the visual evoked potential, was also slow. These abnormalities were reversed by thyroxine.

However, we also demonstrated that correction of hypothermia by central warming led to a more improvement of both of these neurophysiological parameters in untreated patients.

Beghi et al state that using physiological criteria the prevalence of polynoephropathy in hypothyroidism is 71%. Our data suggest, however, that these abnormalities may also be corrected in untreated patients. We found that the sensitivity of energy transfer was significantly higher in untreated hypothyroid patients.3

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Management of intraventricular haemorrhage secondary to ruptured arteriovenous malformation in a child with von Willebrand's disease

The recent report by Omanbach et al1 about a 13 year old girl with von Willebrand's disease and an intracranial arteriovenous malformation raises some important issues.

Their patient developed intraventricular and subarachnoid haemorrhage following minor trauma. Although a bleeding diathesis was diagnosed, a structural vascular lesion was suspected and subsequently confirmed by angiography. The occurrence of an arteriovenous malformation in a patient with von Willebrand's disease is of interest in view of the possible association of this bleeding disorder with various cardiovascular abnormalities, including mild valve prolapse,2 arterial aneurysms,3 gastrointestinal angiodysplasias, and telangiectasias.

It has been suggested that this association represents an underlying mesenchymal disorder of von Willebrand's disease, resembling the heritable connective tissue disorders.4 Abnormalities of the mesenchymal-derived extracellular matrix may be the common ground of, among others, von Willebrand's disease, Ehlers-Danlos syndrome, polycystic


3 Abbott RJ, O'Malley BP, Barnett DB, Timson L, Rosenthal FD. Central and peripheral nerve conduction in thyroid dysfunction: the influence of thyroid hormone therapy in hypothyroidism compared with the effect of thyroxine. Clinical Science 1983;64: 617-22.

kidney disease, mitral valve prolapse, and certain (cerebrovascular) aneurysmal changes.\textsuperscript{11} \textsuperscript{12}

The possibility that von Willebrand's disease is a myocardial or connective tissue disorder enforces the plea made by Dr Osenbach and his colleagues that structural vascular lesions should be ruled out in all patients with von Willebrand's disease who develop intracerebral haemorrhage upon minor trauma.

Osenbach \textit{et al} patient had successful surgical extirpation of the lesion after two weeks of cardiac failure. Administration of the synthetic vasopressin analogue 1-desamino [8-D-arginine] vasopressin (DDAVP) may have been considered in their patient with type I von Willebrand's disease. This type of von Willebrand's disease is characterised by decreased plasma levels of qualitatively normal von Willebrand factor: antigen (vWF:Ag), vWF:Ag strongly promotes platelet-platelet vessel interaction. DDAVP has been shown to stimulate the release of factor VIII and vWF:Ag, shorten or completely normalise bleeding time, and provide surgical haemostasis in patients with von Willebrand's disease and other bleeding disorders.\textsuperscript{11} \textsuperscript{12}

The drug is administered at doses of 0.3 to 0.4 µg/kg body weight by intravenous infusion over 20 minutes. DDAVP was approved by the United States Food and Drug Administration in 1984 for the treatment of the haemostatic defect of von Willebrand's disease. After an adequate response to the drug has been shown before surgery, DDAVP is considered for prophylactic therapy for patients with type I von Willebrand's disease undergoing surgery. Endogenous vWF:Ag released by DDAVP into plasma has been shown to be haemostatically more effective than exogenous vWF infused with plasma concentrates, allowing safe performance of surgical procedures.\textsuperscript{13} Moreover, prolonged bleeding time in patients with severe von Willebrand's disease can be further shortened by DDAVP administration.\textsuperscript{14}

Treatment with DDAVP avoids the risks associated with administration of plasma derived products, for example, viral transmission and allergic reactions. DDAVP administration is associated with very few adverse effects.\textsuperscript{15} Mild facial flushing, probably caused by vasoconstriction of the skin, is most frequently encountered. Other less common side effects are mild and transient headaches, a 10% increase in heart rate, and minor decreases in blood pressure. These reactions can easily be avoided by slowing the rate of DDAVP infusion. DDAVP administration can be repeated at intervals of 12 to 24 hours although some patients treated with this drug at closely spaced intervals may become progressively unresponsive over a period of approximately five days.

\textbf{BOOK REVIEWS}


We doctors love names, and the more confusing and meaningless the better. In the past we could keep patients, lay people, junior staff and even the gods happy, but now names have taken on a totally new life. Speaking as a Consultant Neurological Pathophysiological with neuroanatomical undertones and an interest in neurological rehabilitation and a working day of neuro-epileptology, neuro-psychiatry, neuro-genetics, neuro-dyna and neuro-everything else, I wish this excellent book—which was originally called (or, as the editors say, "described by the appellation") "Neurological Patho-physiology" and is now called "Neurobiology of Disease" and has first class introductions of normal functioning systems—called "Neurology" (ie that branch of science and medicine which deals with the nervous system, both normal and in disease), or is this wish in early manifestations of neuro-demen-
tia representing a loss of neuro-adaptive behaviour, and neuro-intelligence?

The Editors of this book have brought together eminent contributors who have, together with the Editors, written the most readable and worthwhile introduc-
tions to neurology on sale today.

The book, in 2 sections, dealing with functional and anatomical systems, and dis-
case processes, is successful in showing both an introduction to "the scientific basis of neurology" for medical students and "the expression of fundamental mechan-
isms" for scientists in neurobiology, (it provides an introduction—an excellent introduction—to the study of neurology). The first part, entitled "Functional and Anatomical Systems" consists of 12 chapters dealing with normal and demyelinated axons, peripheral nerve, neuromuscular junction, muscle, the somato-sensory system and pain, the auditory system, the visual system, eye movements and vestibular system, the respiratory system, the cardiovascular system, the flexure and memory and amnesia. The second part, "Disease Processes" deals with the genetic disorders (almost entirely about Huntington's disease), seizures, idiopathic and symptomatic epilepsy, and neuro-degenerative diseases, stroke, metabolic encephalopathy, cerebrospinal fluid, blood brain barrier, and brain oedema, brain tumours, infections and Parkinsonism.

The separation into "Functional and Anatomical systems" and "disease processes", is not entirely satisfactory. For example, muscle is dealt with in the first section on "function and anatomic systems" whereas there is an excellent introductory section. Disorders of muscle are also described in this basic section, where there are 4 or 5 pages on inherited muscle disorders, half a page on inflammatory muscle disease, a couple of pages on motor neurone diseases (most of which is on spinal muscular atrophy), and non-dystrophic muscle disease is difficult to find either in the text or in the index. Muscle disease doesn't feature in the section on "disease processes" which seems to be almost entirely devoted to the brain. Similar criticisms pertain to peripheral nerve. "Memory and Amnesia" comes into the section on "Functional and Anatomical Systems" and includes herpes simplex encephalitis which also comes in the section on Disease Processes. It seems rather pointless to divide neurology in this way and to separate disease processes from functional and anatomical systems, particularly since the avowed purpose is to "describe the expression of fundamental mechanisms gone awry, and thereby . . . provide clues for elucidating those mechanisms". There are other places where there is a markedly noticeable lack of balance. For example, acupuncture is given some 19 lines, whereas half that space is given to Melzack and Wall's contribution which has had such a profound effect on the interest and the understanding of pain. There are several, relatively minor errors, which in themselves are perhaps of no great importance. However, book is intended for medical students and the errors should not really have arisen. For example, spinal shock is described as following brain stem lesions or transection of the spinal cord at cervical levels. Spinal shock occurs at any level of transection below the mid-pons. Above this level a transection produces decretebrate rigidity, which is dealt with in much greater detail and more accurately.

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