that there is a considerable shortfall in specialist neurological services in the United Kingdom. The question arises as to whether or not the urgent need for specialist neurological services in the United Kingdom could be met at the current level of funding. It is surprising that over 50% of new referrals were given a priori classification. This high figure may reflect the known long waiting time for "routine" patients, rather than a truly perceived seriousness of the medical condition. It is worth noting that some patients with serious disease were put on the non-urgent list, thus indicating that in some cases at least the initial priority category was inappropriate. These informative referral letters might assist consultants to classify patients appropriately.

In conclusion, this study highlights particularly: 1) the predominance of the diagnostic role of the neurology outpatient consultation; 2) the small proportion of patients referred with serious disease; 3) the unacceptably long waiting time, and 4) the inappropriate priority classification of some patients.

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We would be pleased to consider for publication short letters describing similar audit of outpatient practice in other countries.

Ed


HTLV-I infection: the clinical spectrum widens

A neurological condition causing spastic paraparesis has long been recognised in the West Indies but it was only in recent years that the association between tropical spastic paraparesis (TSP) and human T-cell lymphotropic virus type 1 (HTLV-1) has been confirmed.1,2 Serological tests for HTLV-I can now support a diagnosis of TSP in patients with atypical clinical features.

Patient 1 was born in Jamaica and came to the United Kingdom at the age of 38 years. At the age of 61 years she presented with pain in her left shoulder, a three year history of difficulty raising her arms above her head, fatigue and inability to walk long distances. On examination: she was seen to be spastically walking with both scapulae with weakness in the deltoids, triceps and biceps, without fasciculations. Distal upper limb musculature was normal. The biceps and supinator jerks were absent and there was the triple test. There was a mild spastic paraparesis with increased knee jerks, diminished ankle jerks and extensor plantar responses. Sensory testing was normal. The creatine phosphokinase was mildly elevated and muscle histology revealed neurogenic changes. Myelography and CSF examination were normal. There was a polycylic increase in the serum immunoglobulins.

At first a diagnosis of motor neuron disease was considered but there was no change in her condition during the following four years and reinvestigation revealed serum antibodies against HTLV-I in a titre of 1 in 6400. In TSP, pain is an important feature or present and this was the case. There was a mild spastic paraparesis with increased knee jerks, diminished ankle jerks and extensor plantar responses. Sensory testing was normal. The creatine phosphokinase was mildly elevated and muscle histology revealed neurogenic changes. Myelography and CSF examination were normal. There was a polycylic increase in the serum immunoglobulins.

The initial detection of HTLV-I antibodies was by gel particle agglutination assay and confirmed by more specific methods (ELISA, indirect immunoelectrophoresis, IgG antibody capture radio-immunooassay and Western blot techniques).3 These patients illustrate many of the recognised features of TSP. Although this type of illness in each of them had been tentatively attributed to another cause: motor neuron disease (patient 1), parasaggital tumour or neurosyphilis (patient 2), neuroarosclerosis or neoplasia (patient 3). This is worth noting that initial neurological presentations were pectoral pain and amyotrophy (patient 1), late-onset epilepsy (patient 2) and uveitis (patient 3). TSP was not a diagnosis at presentation: the diagnosis on these patients and should be performed in all West Indian patients with spastic paraparesis and with other unexplained neurological syndromes. If effective treatment with an HTLV-I infection becomes available, early diagnosis will be necessary to identify patients before severe, irreversible neurological damage has occurred. This will require greater awareness of the diverse ways in which TSP may present. The full spec- trum of HTLV-I infection remains to be defined.

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Temporal lobe phenomena during the aura phase of migraine attacks

I report a patient who often experienced temporal lobe phenomena during the aura phase of his migraine attacks. A 27 year old right handed computer