Cerebral localisations in articulatory dyspraxias

Clarke et al reported a case of pure articulatory dyspraxia (pure anarthria, PA) without orofacial apraxia (OFA), in a patient with a predominantly cortical haemorrhagic contusion of the middle frontal gyrus. This paper presented the findings of a comparative study of 175 patients. The authors concluded that PA is predominantly cortical, while OFA is subcortical.

Matters Arising

Neurocysticercotic versus idiopathic epilepsy

I read with interest the letter by Arruda. The conclusion drawn by the author that "Any patient with late onset epilepsy with normal neurological examination and living in an endemic area of taeniasis/cysticercosis should be considered as possibly having neurocysticercosis regardless of the EEG findings" is erroneous. The data presented by the author and literature on the subject do not support such contention. Epilepsy has varied causes in any age group. Arruda et al in a prospective study of late onset epilepsy from India (an endemic area) found cysticercosis as a cause in only 5% of cases, while no cause could be detected in 75% of patients. To say that all these patients had neurocysticercosis because they had normal neurological examination and lived in an endemic area would be stretching the imagination too far. It is interesting that none of the patients in the latter group on follow up which extended to 18 months showed any evidence of neurocysticercosis.

To label all patients of late onset epilepsy with normal examination as neuro-cysticercosis just because the authors did not find any difference in certain parameters studied, is logically incorrect. Since the prognosis and length of treatment required in neurocysticercosis and idiopathic epilepsy may be different, the practical implications of the former statement are obvious. In my opinion, the conclusion drawn by the author is not supported by facts, is unscientific and dangerous.

G K AHUJA

All India Institute of Medical Sciences, New Delhi-110029, INDIA

Arruda reply: I appreciated the comments by Dr Ahuja and I quite agree that the conclusion as presented is misleading. In fact, a single but essential word is missing in the final sentence: possibly! It should read: "Any patient with late onset epilepsy with normal neurological examination and living in an endemic area of taeniasis/cysticercosis, should be considered as possibly having neurocysticercosis regardless of the EEG findings." This conclusion is supported by previous studies showing neurocysticercosis (NC) in 25-50% of patients with late onset epilepsy and living in endemic areas of these diseases in Brazil and Mexico. Ahuja and Mohanta report a much lower prevalence of NC in Northern India (5%). Nevertheless, NC should always be considered in any patient with late onset epilepsy even in these populations due to its possible therapeutic and prognostic implications.

R WO ARRUDA
Rua Gonçalves Dias 713,
80-240 Corumbá PR,
BRAZIL


Isolated muscle hypertrophy as a sign of radicular or peripheral nerve injury

The article by Martle et al showed that hypertrophy of a single muscle can be a sign of partial nerve or ventral root lesion, and this diagnosis is confirmed by the presence of "profuse spontaneous activity in the hypertrophic muscle." However, an article about the proposed diagnostic value of this somewhat arbitrary EMG sign and the authors' suggestion that knowledge of this clinical sign might be necessary, costly, and sometimes invasive investigations, in search of for example, "focal myositis or muscle neoplasms," have been seen with atypical tumours of the calf with profuse spontaneous activity in the "hypertrophic" muscle. Case 1