We report the therapeutic results with Octreotide, a somatostatin analogue, in two subjects who became resistant to the usual medication. The trial arose from previous experience with diabetic diarrhoea,[2] also a dysautonomic manifestation. In FAP we accept that there is a blind loop phenomenon with bacterial overgrowth and a mild malabsorption as in diabetic dysautonomic diarrhoea.

The first patient, a 53 year old man whose disease had began four years previously, had diarrhoea (7 times per day) for six months, orthostatic hypotension and loss of weight (3 kg). The other patient, a 43 year old man whose symptoms started seven years ago, had less severe diarrhoea (4 times per day) for two months sufficient to cause psychological disturbance and deterioration in orthostatic hypotension. The diarrhoea in these patients was painless and watery and the stools contained no blood, pus or mucus.

Octeotride 0·05 mg was administered by subcutaneous injection every 12 hours. The first patient was treated for 15 days which resulted in an improvement in his diarrhoea (3 times per day and stools semiformed) and orthostatic hypotension; his weight also stabilised. The second patient was also given the same therapy for seven days. The diarrhoea became less frequent (twice per day) and the stools semiformed; orthostatic hypotension also improved as did his psychological state. This patient reported mild nausea during the treatment. Each injection improved symptoms after 30–60 minutes and relief continued for 24–48 hours. After this period, the mild deterioration experienced in both patients was controlled with the usual therapy during the three to four months follow up.

Octeotride should be considered in the treatment of refractory diarrhoea in FAP.

MAMEDE CARVALHO
MANUELA ALVES
M L SALES LUIS
Neurology Department,
Centro de Estudos Egas Moniz,
Hospital de Santa Maria,
Lison, Portugal

Correspondence to: Dr Alves

1 Andrade C. A peculiar form of peripheral neuropathy. *Brain* 1952;75:408–27.
2 Tsai ST, Vinik AI, Brunner JF. Diabetic diarrhoea and somatostatin. *Ann Intern Med* 1986;104:894.

MATTERS ARISING

Angiostrongylus cantonensis

I believe that the authors of a case report[1] of *Angiostrongylus cantonensis* occurring in a brain abscess of a patient from India have misidentified the parasite and that this does not represent a case of human angiostrongyliasis but is in fact a case of sparganosis caused by a tapeworm parasite of the genus *Spirometra*. I suggest this alternative diagnosis for the following reasons:

1) Although *A cantonensis* infection is common in south east Asia, many parts of the Pacific region and other parts of the world, I know of no published reports of the parasite occurring in India although I have heard anecdotally that rat infections have been seen there. I do not believe any human infections have been previously reported in India.

2) The clinical picture described in the report is at variance with what we generally see in eosinophilic meningoencephalitis associated with *A cantonensis* infection. When the authors state "this case is unique in that the patient presented with focal neurological manifestations . . ." it agrees with a diagnosis of neurocysticercosis or sparganosis but not Angiostrongylus. Thus a brain abscess picture with a single focal lesion, no reported eosinophilia in blood or CSF, is far more consistent with the diagnosis I suggest.

3) Finally, the lesion pictured in figs 2 and 3, and in particular 3 which is supposed to be the actual worm, do not illustrate a nematode. The tegument of the tapeworm is clearly seen in fig 3 and its histological features are consistent with a larval tapeworm and certainly have no features of a roundworm in section. I would suspect that at a slightly higher magnification calcareous corpuscles would be clearly visible in the tegument which are unique to cestode tissue. You can barely make them out in fig 3 now but it is too low in magnification to be absolutely certain. The fact that the authors state that the worm was living and motile when the lesion was opened suggests sparganosis rather than cysticercosis. In addition there is no bladder visible which you see with cysticercosis.

LAWRENCE R ASH
School of Public Health,
University of California,
Los Angeles, California, USA

1 Purohit AK, Dinakar I, Sundaram C, Ratnakar KS. *Angiostrongylus cantonesis* abscess in the brain (letter). *J Neurol Neurosurg Psychiatry* 1991;54:1015.

Dr Purohit et al reply:

It is not that human and rodent infestations have not been reported from India. There are enough publications to suggest that this infestation does occur in India.[1] The absence of eosinophilia can occur in parasitic infestations where the pathology is localised, for example, occurrence of abscess.

However, after reading the comments in the letter by Dr Ash and a publication by Chans *et al*[2] we have reviewed the histopathology slides and have found no calcareous corpuscles in the tegument.

We have, however, found the following important positive features to suggest that the worm could be a sparganum: 1) Pseudo segmentations; 2) longitudinal excretory channels and 3) classical muscle bundles in the parenchyma.

Considering the possibility that the calcareous corpuscles must have dissolved during fixation the worm in question is most likely a sparganum and this case report of abscess by this parasite is definitely a very rare entity.

A K PUROHIT
I DINAKAR
C SUNDARAM
K S RATNAKAR
Departments of Neurosurgery and Neuropathology,
Nizam's Institute of Medical Sciences,
Panjagutta, Hyderabad, India

1 Lalita S, Limayel, et al. Serological investigations of a suspected case of human angiostrongyliasis. *Indian J Pathol Microbiol* 1988;31:3, 248–50.
2 Chans ST, *et al.* Sparganosis of the brain: report of two cases. *J Neurosurg* 1987;3: 931–7.

Hypergraphia associated with a brain tumour of the right cerebral hemisphere

We read with great interest the recent paper by Imamura *et al*[1] on hypergraphia and brain tumour and their grouping of hypergraphia into two different neurobehavioural abnormalities.

We reported in 1984[2] another group of patients who exhibited hypergraphia—namely the mentally handicapped. We found thirty three patients with hypergraphia, of which 18 were male and 15 female. The ages ranged from 14 to 70 years (mean age 39·5) and the IQs ranged from 13 to 70 (mean IQ 32).

Five patients had temporal lobe epilepsy and thirteen others had a history of epilepsy. Six had superimposed psychiatric disorder (four with epilepsy) and other patients showed considerable behaviour disorder with aggressive outbursts as a prominent feature. There were also four patients with Down's syndrome.

Further studies are needed to determine the cause of this phenomenon and the precise localisation of the responsible lesion.

J JANCAR
LEILA B COOKE
Stoke Park Hospital, Stapleton,
Bristol BS16 1QU, UK

1 Imamura T, Yamadori A, Tsuburaya K. Hypergraphia associated with a brain tumour of the right cerebral hemisphere. *J Neurol Neurosurg Psychiatry* 1992;55:25–7.
2 Jancar J, Kettle LB. Hypergraphia and mental handicap. *J Ment Defic Res* 1984;28:151–8.

Imamura et al reply:

We thank Drs Jancar and Cooke for their comments. We did not cite several mass studies[1–3] in our article, because we could not judge their hypergraphia as Waxman or Yamadori type. It is possible that these studies included a third type of hypergraphia.

TORU IMAMURA
KENJI TSUBURAYA
Department of Neurology,
Tohoku Kohseinenkin Hospital,
Sendai, Japan
ATSUSHI YAMADORI
Neurology Service,
Hyogo Brain and Heart Centre at Himeji,
Himeji, Japan

1 Hermann BP, Whitman S, Arntson P. Hypergraphia in epilepsy: is there a specificity to temporal lobe epilepsy? *J Neurol Nuerosurg Psychiatry* 1983;46:848–53.
2 Jancar J, Kettle LB. Hypergraphia and mental handicap. *J Ment Defic Res* 1984;28:151–8.
3 Hermann BP, Whitman S, Wyler AR, Richey ET, Dell J. The neurological, psychological and demographic correlates of hypergraphia in patients with epilepsy. *J Neurol Neurosurg Psychiatry* 1988;51:203–8.