Leiguarda et al. reply: We appreciate Okuda and Tachibana’s comments about our apraxia in corticobasal degeneration because they enable us to clarify the status of limb-kineti- c apraxia, a point which is particularly relevant for the clinical interpretation of the apractic disorders in patients with cortico- basal degeneration.

Limb or melokinetic apraxia (originally called “innervatory apraxia” by Kleist)3 was considered by Liepmann to be a form of limb-kineti- c apraxia.5 The lesion of “innervatory engrams” secondary to “sen- sorimotor” damage.6 The disorder is characterised by clumsiness in the perfor- mance of fine motor acts by the hand contralateral to the hemispheric damage. All types of movements including gestures, regardless of whether the patient creates or imitates them, become “uncouth, clumsy, inexpert, and preceded by fruitless attempts which only bring the wrong muscles into play.”4

The status of limb-kineti apraxia has been debated for over three decades. Most authors have refused to consider symptoms connected with limb-kineti apraxia as apractic.6 Geschwind disregarded it completely7 and Rothi et al. failed to include limb-kineti apraxia in their neuropsychologi- cal model of limb praxis.8 Brain concluded that it is simply a partial symptom of pyramidal tract lesion,9 a view also shared by Ajuriaguerra and Tissot,10 Hecaen and Rondot,11 and Mesulam.12 De Renzi in par- ticular contends that “limb-kineti apraxia has never been described with sufficient accuracy to be distinguishable from a mild form of paresis” in gain acceptance by neurologists.13 In support, monkeys with lesions restricted to the corticospinal tract show similar errors.14

This may be an extreme view of limb- kineti apraxia. Liepmann’s definition of apraxia may be summarised as a deficit in the performance of purposeful skinned move- ments, in the absence of elementary motor (weakened, akinetic, abnormal posture, or tone) or sensory deficits, or of impaired comprehension or memory.15 The disruption of movement seen in lesions of the corti- cospinal pathway, or as seen in Parkinson’s disease, can seldom be fully explained by weakness, akinnesia, abnormal posture, or tone. There is additional breakdown of the movement pattern or formula— Liepmann’s innervatory engramer— that sug- gests a higher motor disorder or apraxia. This is exactly what is seen at a pronouced degree in corticobasal degeneration, partic- ularly in the initially affected limb. To this extent we agree with Okuda and Tachibana. Our study also shows that many patients with corticobasal degen- ration likewise fail the ideomotor apraxia, a failure that we do not think can be explained by limb-kineti apraxia alone.


NOTICE

The winter meeting of The British Neuropsychiatric Association will take place in the Conference Theatre London Zoo, on 20 January 1995. The subject will be the neuropsychiatry of vascular disease. For further information please contact Sue Garrett, Administrative Assistant BNPA, 17 Clocktower Mews, London N1 7VU, UK. Telephone/fax 071-226 5949.

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, expiry date, and your full name.


When the Editor sent this little book to me for review my first response was “Oh dear, another psychiatric vade-mecum”. Other texts about psychiatric emergencies suggest that authors often have difficulty finding enough to say about psychiatric emergen- cies, with the result that what emerges is a short textbook of psychiatry rather than a text more precisely focused upon emergen- cies. That can only be done from the per- spective of a casualty officer. That is exactly what these authors have achieved by compil- ing the views of some thirty contributors most of whom, I suspect, have had signif- icant experience of taking-on-call in a busy modern general hospital.

The initial section is a series of contribu- tions providing practical and explicit guid- ance about the assessment of different presenting problems; The Emergency Psychiatric Evaluation, with special empha- sis upon neuropsychiatric evaluation, Crisis, The Suicidal Patient, Acute Grief and Disaster Victims, Families
