

interesting and unusual features. (1) There is an exceptionally long interval of 26 years between the original presentation and recurrence. We have found one reference to a late recurrence of 27 years but there are no details of that case published.³ Ninety per cent of all incompletely removed craniopharyngiomas recur within 10 years, most in the first postoperative year.³ In a review of 245 cases the average time between first and second operation was three years.⁴ A recent series performed since the advent of microsurgery and better imaging techniques stressed the increased likelihood of recurrence in the adamantinomatous type of craniopharyngioma⁵; the longest interval between surgery and recurrence was eight years in adults and five in children (follow up period 13 years).

(2) This patient presented as a cerebellopontine angle tumour. Of five published accounts of craniopharyngioma shown to extend to the cerebellopontine angle by CT, only three actually presented with clinical symptoms of a cerebellopontine angle tumour. Our case had fifth nerve compression only, and had excellent recovery after operation. Trigeminal nerve palsy has not, to our knowledge, been reported before as the presenting sign in craniopharyngioma. The overwhelming majority are suprasellar but extension into the anterior, middle, or posterior fossa may sometimes occur. Only 4% of Petito's series extended into the posterior fossa.⁴

(3) The relatively normal endocrine and sexual function in our patient is unusual. Endocrine deficiency may be due to the tumour itself damaging the hypothalamic-pituitary pathways, or to treatment including surgery, irradiation, and chemotherapy. Endocrine deficiency is the most common of the potential hazards of radiotherapy after craniopharyngioma. The hypothalamic-growth hormone axis seems to be the most vulnerable, then the gonadotrophins and ACTH and TSH.² This patient is obese and of short stature so she is probably growth hormone deficient. Testing for growth hormone was not performed as replacement was not considered. Our patient has normal gonadotrophin activity, as evidenced by normal menstruation and pregnancy, despite the large field of radiation she received. Many women with craniopharyngioma have primary amenorrhoea and require ovarian stimulation to achieve pregnancy. The pituitary gland itself is relatively protected, however, in irradiation for craniopharyngioma. We believe that in this patient, because the mass subsequently extended into the posterior fossa, the hypothalamic-pituitary axis was spared from local destructive effects.

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MATTERS ARISING

Dementia and door-to-door studies in Spain

Coria *et al*¹ have recently published a very original and interesting paper on prevalence of dementia in a rural population in Spain (Turégano). The authors claim that this study is the first door-to-door survey performed in a definite community in Spain. This statement could lead to some misunderstanding because, in fact, there are more data on prevalence of dementia in Spain obtained from door-to-door surveys. In the past five years, several door-to-door surveys on prevalence of dementia have been performed in Spain. The first reported in English was carried out by Lopez-Pousa *et al*² in a random sample of eight towns in Gerona in 1991. The second described in English is the Zaragoza-Liverpool study (a study based on a random sample of old people in an urban city).³ Another door-to-door survey reported in May 1993 in English was carried out by Bermejo *et al* as a random sample of old people from four districts of Madrid.⁴ The preliminary data of these three studies have been reported previously in Spanish.⁵ More studies have been carried out (Toledo; Pamplona; Baix de Camp, Tarragona) but as yet these studies are unpublished, apart from some preliminary data.⁵

It is noteworthy that all published studies have been performed with standardised neuropsychological protocols (CAMDEX, GMS), and international diagnostic criteria (DSM-III or DSM-III-R) and all these studies are door-to-door surveys. The most outstanding fact is that the data of prevalence of dementia (people over 60 or 65 years) are quite different and range between 14.2% in Gerona to 5.2% in Turégano (10% in Madrid, 6.7% in Zaragoza).¹⁻⁵ But there is a uniform finding: Alzheimer's disease is the most frequent cause of dementia in these Spanish surveys, as it is in others done in Western countries.

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- 1 Coria F, Gómez del Caso L, Minguez L, Rodríguez-Artalejo F, Clavería LE. Prevalence of age-associated memory impairment and dementia in a rural community. *J Neurol Neurosurg Psychiatry*, 1993;56:973-6.
- 2 López-Pousa S, Vilalta S, Llinás J, et al. Prevalence of dementia in the general population: pilot study in Girona (Spain). *Neuroepidemiology*, 1991;10:99.

Coria replies:

Many different groups in Spain are conducting epidemiological studies on dementia, as claimed by Bermejo and Morales above. Nevertheless, ours is still the first to address the prevalence of age-associated memory impairment, using validated instruments.^{1,2} The only available definitive data on the prevalence of dementia in Spain were included in the EURODEM study, and the results of this study were referenced (see ref. 19 in ref. 1). The high prevalence of dementia found in one study³ is probably caused by the inclusion of cases with mild dementia and age-associated memory impairment. Subtraction of these cases gives prevalence rates of overt dementia similar to those found in Segovia (Lopez-Pousa, personal communication).

In any case, analysis and meta-analysis of the extensive data on the subject now available in Spain would provide a good opportunity to address several controversial issues related to the methodological problems associated with epidemiological studies on dementia and other related disorders. In addition, these studies should provide large numbers of well studied cases for molecular and genetic analysis of the early stages of Alzheimer's disease.⁴

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NOTICE

The second joint meeting of the **British Neuropsychiatric Association** and the **American Neuropsychiatry Association** will take place in New Port, RI, USA on 21-24 July 1994. For further information, contact Professor M A Ron, Department of Neuropsychiatry, The National Hospital, Queen Square, London WC1N 3BG. Tel: + 44 71 837 3611; fax: +44 71 829 8720.