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 lesion of 27 years but there are no details of that case published. Ninety per cent of all incompletely removed craniopharyngiomas recur within 10 years, most in the first postoperative year. (1) In a review of 245 cases, the average time between the 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 patients with continuous type of craniopharyngioma; the longest interval between surgery and recurrence was eight years in adults and five in children (follow up 14 years). (4)

(2) This patient presented as a cerebellar-pontine angle tumour. Of five published accounts of craniopharyngioma shown to extend to the cerebellar-pontine angle by CT, only three actually coexisted with typical symptoms of a cerebellar-pontine 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. (1) 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 growth hormone as evidenced by normal menstruation and pregnancy, dispite the large field of radiation she received. Many woman with craniopharyngioma have primary amenorrhea 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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3 Wilkins RH, Rengachary SS. Neurooncology.


Coria replies: Many different groups in Spain are conducting epidemiological studies on dementias, as claimed by Bermejo and colleagues above. Nevertheless, ours is still the first to address the prevalence of age-associated memory impairment, using validated instruments. (1) The only available definitive data on the prevalence of dementia in Spain were included in the EURODEEM study, and the results of this study were referenced (see ref 19 in ref 1). The high prevalence of dementia found in one study (1) 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 Spain (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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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.