they may relate to the high frequency of the 11 778 mutant allele in the retinal cell layer and optic nerve, V are still unclear.

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Painless ischaemic lumbosacralplexopathy and aortic dissection

There is only one case report dealing with ischaemic lumbosacralplexopathy without simultaneous signs of limb ischaemia.1 We present a similar case characterised by the total absence of pain. A 69 year old man suddenly developed a weakness and a numbness of the right leg. He also complained of vague abdominal discomfort but no pain was felt in the leg. His risk factors included arterial hypertension and angina pectoris. He was not diabetic. The clinical examination showed no pronounced global weakness (grade 0-2/5) of the right lower limb, including the hip flexors and the gluteal muscles. The knee jerk and the ankle jerk were abolished. Sensory disturbances were found below the L2 level on the right side. Light touch and proprioception were clearly impaired whereas sensation for pain and temperature was less diminished. The diagnosis of peripheral neuropathy was ruled out and the normality of the results of the nerve conduction studies was documented.

An EMG taken two weeks later showed almost no voluntary motor unit potentials in the iliopsoas, quadriceps, glutei and adductor muscles. Recruitment of motor units was much reduced in other muscles of the right lower limb. Fibrillations and positive sharp waves were absent. Nerve conduction studies showed absent right sural and superficial peroneal sensory responses and low amplitude right tibial and peroneal motor responses.

The patient had hypertensive treatment in the intensive care unit but dissection extended to the aortic arch causing haemopericardium and the patient died four weeks later. A necropsy was not performed.

Our patient probably had an acute ischaemicplexopathy. The sudden beginning of the clinical picture “like an apoplexy” was in favour of a vascular aetiology. The diagnosis of more distal neuropa-thies was not suspected as an angiography of the lower limbs of this patient was strictly normal. Ischaemic neuropathies are divided into those occurring with diseasesaffecting large arteries and those occurring with dissection as diagnostic of such large arteries. Acute ischaemia of peripheral nerves generally results from occlusion of a main proximal limb artery or from occlusion of many distal arteries. The rareness of such neuropathies can be explained by the relative resistance of peripheral nerves to ischaemia. It results from their slight metabolic needs (oxygen requirement of human nerve = 0.3 ml/100 g) and from the presence of small arteries which provide a generous blood flow (43 ml/100 g/min).2 The nutrient arteries that supply peripheral nerves enter the epineurium and form a collateral vascular network of inter-fascicular arteries along the length of thenerve, so that it is difficult to infarct a peripheral nerve. The intensity of nerve damage varies with the number of nutrient vessels, the availability of the collateral circulation, age of the nerve and the pattern and particular duration of arterial occlusion.

The different fibres that constitute peripheral nerves seem to be altered selectively by ischaemia. In some studies, anoxia seems to affect the small fibres before the large ones and Schwann cells seem to be more resistant to anoxia than axons. Nevertheless, opposite data are found in other studies, which suggest a greater vulner-ability of large fibres.

Clinical features of ischaemic neuropathy are generally stereotyped.3 Sensory deficits are more frequent than motor deficits. In particular, mononeuropathies with deep burning pain and neurological examination usually shows impairment of all sensory modalities or pattern of sensory loss that spares the large fibres. There are no signs of muscle necrosis. An EMG usually shows abnormalities consistent with axonal damage. Conduction blocks are unusual.

Such ischaemic lumbosacralplexopathies have been reported after aortobiemoral graft and aortofemoral bypass graft by resection of nutrient arteries, after use of an intra-aortic balloon, and after vasospasm caused by an injection of drugs into an infe-rior gluteal artery. Only one case of painful ischaemic lumbo-sacralplexopathy due to an aortic dissection has been reported.4

Anatomically, the lumbosacralplexus is supplied by five lumbar arteries, which origi-nate from the abdominal aorta, the deep circumflex iliac artery, a branch of the external iliac artery, and the iliolumbar and gluteal branches of the internal iliac artery.5 In our patient, ischaemia of the lumbosacralplexus could be due to interruption of blood flow through the lumbar segmental arteries and branches of the iliac arteries secondary to the dissection of the aortic artery walls and of the most proximal iliac artery walls just below the aortic bifurcation.

The clinical picture in our patient was also characterised by the absence of pain whereas causalgia like burning is generally common in acute and chronic ischaemic neuropathies.

Absence of pain has rarely been reported in ischaemicplexopathies. Clinical and pathological studies of nerves in painful neuropathies have been limited but the occurrence of pain is usually related to a selective damage of unmyelinated and myelinated small fibres. In the same way, painless neuropathies seem to be related to a selective damage of large fibres, as in our patient. On the other hand, a selective loss of fibres has not been confirmed by other studies, in which the ratio between large and small fibres was not modified.6

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Electroconvulsive therapy for the physical signs of Parkinson's disease without depressive disorder

Faber and Trimbale1 have reviewed the reports on electroconvulsive therapy (ECT) in Parkinson's disease. We conducted a prospective open trial to evaluate the short term benefit of ECT on the physical signs of Parkinson's disease without major depressive disorder. This is a stated comparison of two groups. The ECT treatment was given unilaterally to the non-dominant hemisphere over eight days. Approval for the study was given by the ethics committee, Royal Hobart Hospital and all patients gave written informed consent.

Fifteen patients (12 men) participated. Five failed to comply with all assessments and were therefore eliminated from the analyses. The remaining population (seven men and three women) had an average age of 64-8 years. The time since initial diagno-sis of Parkinson's disease ranged from two months to 16 years. Most were severely

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