LETTERS TO THE EDITOR

Cerebral metabolism during vegetative state and after recovery to consciousness

One way to approach the study of consciousness is to explore lesions in cases in which impairment of consciousness is the prominent clinical sign. Vegetative state is such a condition wherein awareness is abolished whereas arousal persists. It can be diagnosed clinically soon after a brain injury and may be reversible (as in the following case report) or progress to a persistent vegetative state or death. The distinction between vegetative state and persistent vegetative state is that the second is defined as a vegetative state that has continued or endured for at least 1 month. We present a patient who developed a vegetative state after carbon monoxide poisoning and in whom we had the opportunity to measure brain glucose metabolism distribution during the vegetative state and after recovery to consciousness. Using [F]fluoro-deoxyglucose (FDG) PET and statistical parametric mapping (SPM) we compared both patient’s sets to a normal control population. Our findings offer an insight into the neural correlates of "awareness", pointing to a critical role for posterior associative cortices in consciousness.

A 40 year old right handed woman attempted suicide through CO intoxication and was found unconscious. She was treated with hyperbaric oxygen but evolved to a vegetative state diagnosed according to the following criteria: (1) spontaneous eye opening without evidence of awareness of the environment; (2) no evidence of reproducible voluntary behavioural responses to any stimuli; (3) no evidence of language comprehension or expression; (4) intermittent wakefulness and behaviourally assessed sleep-wake cycles; (5) normal cardiorespiratory function and blood pressure control; (6) preserved pupillary, oculocephalic, corneal, and vestibulo-ocular reflexes. Brain MRI performed 14 days after admission was normal. Electroencephalography showed a 6 Hz basal activity with more pronounced slowing on the left parietal regions. Auditory evoked potentials were normal. Somaesthetic evoked potentials of the median nerve showed normal latency and amplitude of P14 and N20 potentials without any late cortical components. After remaining in a vegetative state for 19 days the patient regained consciousness. Her sequela consisted of a bilateral spastic paresis of upper and lower limbs. Neuropsychological testing 1 month after admission showed an attention deficit with moderate impairment of short term memory. One year after the accident she showed a spastic gait with altered fine motor function, most prominent on the right, a slurred speech, and minor short term memory disturbances. FDG-PET was performed during the vegetative state (day 15 after admission) and after recovery to consciousness (day 57).

The control population consisted of 48 drug free, healthy volunteers, aged from 18 to 76 years (mean: 42 (SD 21) years). The study was approved by the ethics committee of the University of Liège. Informed consent was obtained by the husband of the patient and for all control subjects. Five to 10 mCi FDG was injected intravenously; PET data were obtained on a Siemens CTI 951 R 16/31 scanner in bidimensional mode. Arterial blood samples were drawn during the whole procedure and cerebral metabolic glucose rates (CMRGlu) were calculated for all subjects. PET data were analysed using SPM software (SPM96 version; Welcome Department of Cognitive Neuroscience, Institute of Neurology, London, UK). The use of SPM to assess between subject (rather than within subject) variability is unlikely to alter the relevance of our results given their high degree of significance. Data from each subject were normalised to a standard stereotactic space and then smoothed with a 16 mm full width half maximum isotropic kernel. The analysis identified brain regions where glucose metabolism was significantly lower in each patient scan compared with the control group. The resulting foci were characterised in terms of peak height over the entire volume analysed at a threshold of corrected p<0.05.

During the vegetative state, average grey matter glucose metabolism was 38% lower than in controls (4.5 ± 7.3 (SD 1.4) mg/100 g/min). No substantial change in mean CMRGlu was found after recovery (4.7 ± 2.7 mg/100 g/min). During the vegetative state, significant regional CMRGlu decreases were found in the left and right superior parietal lobe; the left inferior parietal lobe; the precuneus; the left superior occipital, superior and middle temporal gyri; and the premotor and postcentral and precentral cortex (figure, yellow colour). After recovery, metabolic impairment was confined to the left and right precentral and postcentral gyri and premotor cortices (figure, blue colour).

This case report offers an insight into the neural correlates of human consciousness (at least, external awareness as it can be assessed at the patient’s bedside). Given that global glucose utilisation levels remained essentially the same, the recovery of consciousness seems related to a modification of the regional distribution of brain function rather than to the global resumption of cerebral metabolism. The main decreases in metabolism seen during the vegetative state but not after recovery were found in parietal areas, including the precuneus. This is in agreement with postmortem findings in persistent vegetative state, in which involvement of the association cortices is reported as a critical neuroanatomical substrate and with PET studies in postanoxic syndrome, in which the parieto-occipital cortex showed the most consistent impairment. The functions of these areas are manifold: lateral parietal areas are involved in spatial perception and attention, working memory, mental imagery, and language, whereas the precuneus is activated in episodic memory retrieval, modulation of visual perception by mental imagery, and attention. Our data point to a critical role for these posterior associative cortices in the emergence of conscious experience.

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Localisation of voxels in which cerebral glucose metabolism was impaired during vegetative state (in yellow) and after recovery to consciousness (in blue), compared with the control population. SPM(3) threshold was set at voxel level corrected p<0.05 and projected on the patient’s coregistered MRI, normalised to the stereotaxic space of Talairach.
Acute overdosage and intoxication with carbidopa/levodopa can be detected in the subacute stage by measurement of 3-<i>methylidopa</i>

Although the effects of a chronic overdosage with levodopa are well known, few cases of acute intoxication have been described. A particular problem in establishing a diagnosis of levodopa overdosage is that the patient may have only half the life in the circulation of levodopa. If there is a delay in bringing an acutely intoxicated patient to hospital, perhaps due to late discovery, the blood concentration of levodopa could already be too high, especially the peak levodopa concentration in Parkinson’s disease therapy) after 6–8 hours. Depending on the extent of the overdosage, the time could be even shorter. This report describes the clinical effects and the plasma concentrations of levodopa and specific metabolites over a period of 132.5 hours after ingestion of 30 tablets of carbidopa/levodopa (50 mg/200 mg tablets).

A 76 year old patient had a pre-existing mild akinetic rigid Parkinson’s syndrome, which had been treated for the past 1.5 years with 3×1 tablets of carbidopa/levodopa (50 mg/200 mg) a day without a substantial response. The weight of the patient was 74 kg. A known chronic obstructive airway disease was treated with a home oxygen appliance. At about 8.30 pm, the patient had attempted suicide by taking 30 tablets of carbidopa/levodopa. About 9.00 pm he attempted to sleep, and was experi-encing visual hallucinations; he was restless, tossing and turning, and getting out of bed. He did not represent peak dose dyskinesia or Parkinson’s syndrome or dyskinesia. Arterial blood pressure was 160/90 mmHg. No other abnormal blood pressure was noted. The weight of the patient was 74 kg. A known chronic obstructive airway disease was treated with a home oxygen appliance. At about 8.30 pm, the patient had attempted suicide by taking 30 tablets of carbidopa/levodopa. About 9.00 pm he attempted to sleep, and was experiencing visual hallucinations; he was restless, tossing and turning, and getting out of bed. He did not represent peak dose dyskinesia or Parkinson’s syndrome or dyskinesia. Arterial blood pressure was 160/90 mmHg. No other abnormal blood pressure was noted. The weight of the patient was 74 kg.

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Distribution into muscles rather than metabolism may largely determine the plasma half life of levodopa and explain why this was only slightly altered with overdose. The measured peak concentration of 66 763 ng/ml is about 30 times higher than the peak concentration to be expected after taking one tablet of carbidopa/levodopa (50 mg/200 mg). It is apparent that the 30 tablets did not interfere with absorption or lead to a gastrointestinal paralysis due to the high dose of levodopa; the relation between amount ingested and plasma concentration seems to be linear, at least in this dose range.

We conclude from these findings that in cases of suspected levodopa intoxication some hours previously, it could be important to measure the concentration of 3-\text{o}-methyldopa, so as not to overlook an overdose with levodopa, which may be due to a suicide attempt. In addition to the diagnostic uncertainty in relation to the immediate treatment of the patient, this would also have an effect on further psychiatric and psychological therapy.

**The use of olanzapine for movement disorder in Huntington’s disease: a first case report**

Movement disorder is a prominent feature of Huntington’s disease and consists of involuntary and voluntary components as well as associated bradykinesia. Pharmacological treatment is problematic because of the side effects of the drugs used, which may further compromise cognitive functioning and mobility. Patients are often not subjectively aware of their movements but can be considerably disabled by them and carers are often distressed and enquire about treatment options. If drug treatment is considered it is important to achieve the maximum improvement in movements with the minimum of negative side effects. This paper describes the effect of olanzapine on movements when other treatment options had been ineffective or limited by side effects.

Huntington’s disease is a hereditary progressive neurodegenerative disorder. It consists of a triad of symptoms comprising motor, psychological, and cognitive abnormalities. The motor component consists of involuntary choreiform movements and increasing difficulties with voluntary movement. The degree of the involuntary movements is variable but in some patients can be very marked. Progression over time of the movement disorder in Huntington’s disease can be monitored using the quantitative neurological examination (QNE). This measure has three subscales, an eye movement scale, a motor impairment scale (MIS) quantifying voluntary movements, and a chorea measurement scale quantifying involuntary movement.\(^2\)

Pharmacological control of the symptoms has been shown to be effective with dopamine antagonists,\(^1\) but their use is limited because of the side effects. Clinically, the most problematic of these are sedation, cognitive slowing, increased mobility problems, and hypotension. The inability of traditional dopamine antagonists to improve functional capacity, despite ameliorating toxicity, is probably due to suppression of voluntary motor activity.\(^1\)\(^4\) Tardive dyskinesia has occasionally been reported in patients with Huntington’s disease treated with these drugs.\(^5\) The atypical antipsychotic clozapine has been shown to be effective in improving the movement disorder. However, in a double blind randomised trial of clozapine which included patients who were already receiving traditional antipsychotics and mood stabilisers, a group who had not received drug treatments for their movement disorder, chorea was reduced in those who were antipsychotic naive only and the authors concluded that clozapine was of little added benefit in Huntington’s disease.\(^6\) Olanzapine is a new atypical antipsychotic drug. It is a thienobenzodiazepine structurally very similar to clozapine. Unlike clozapine it is not associated with the potentially serious side effect of agranulocytosis and therefore frequent blood monitoring is not necessary.

This report describes the progress of a man who has Huntington’s disease. He developed a marked movement disorder and was unable to tolerate both sulpiride and risperidone but had symptomatic improvement when treated with olanzapine.

He is a man in his early 50s who had a confirmatory genetic test for Huntington’s disease in 1994, after the development of clinically obvious motor symptoms. It is likely that the onset of symptoms had occurred a few years previously as he had experienced difficulties in concentration and coordination at work, attributed at the time to stress, leading to the loss of employment. In addition his family, watching family videos of a few years earlier, thought that there were early signs of his movement disorder. However there was no known family history of Huntington’s disease which might have led to an earlier diagnosis. By May 1995 his involuntary movements were becoming more noticeable, although control of voluntary movement was good. A trial of sulpiride commencing at 200 mg twice daily and increasing over 1 week to 800 mg daily was undertaken with a subsequent decrease in the frequency and extent of involuntary movement recorded in case notes; unfortunately the QNE was not repeated at this time. However, the patient experienced a subjective slowing of his cognitive processes, concurrently became depressed and decided to stop the treatment within 3 weeks. Paroxetine, a selective serotonin reuptake inhibitor antidepressant, was started at a dose of 20 mg a day, which led to an improvement in his low mood. His involuntary movements continued to cause difficulties in his daily living. He was unable to sit comfortably in a chair and when out of doors felt that he was being knocked into them. He agreed to a trial of...
risperidone. This was started at a dose of 1mg twice daily, increasing to a dose of 1mg four times a day over a period of 2 weeks, stopped after a brief period. He developed hypotension (blood pressure 100/60 mg Hg), complaining of dizziness after the initial dose. His blood pressure remained stable, although low, after this and as there was improvement in his movements the drug was continued. However, he decided to stop the risperidone after 4 months because of his subjective experience of slowed thinking and occasional dizziness. A repeated trial of sulpiride was carried out in March 1997. Sulpiride was started at a dose of 200 mg twice a day and increased to a total daily dose of 1000 mg over 2 weeks. He was on sulpiride for 4 weeks without any improvement in his movements, so it was discontinued. The patient continued to experience low mood and after the discontinuation of sulpiride, his antidepressant drug was changed to lofepramine commencing at 20mg daily. There were no changes noted in his movements during this change. The principal site of interaction of olanzapine with dopaminergic receptors is the D2 receptor, although it also acts at other receptors such as D4, 5HT2A, 5HT2C, 5 HT3, α1-adrenergic, histamine H1, and 5 muscarinic receptors. This binding profile is similar to clozapine, another atypical antipsychotic drug, but substantially different to the conventional antipsychotic haloperidol. The preferential loss of D2 projection neurons which are involved in a feedback loop normally active in the suppression of involuntary movements is thought to be the pathological basis of chorea in patients with Huntington’s disease. The D2 antagonist properties of olanzapine may explain its possible benefits in the improvement of chorea. However, the effect at other receptors such as D4 may also be important, as D4 receptor density has been shown to be raised in Huntington’s disease. Transient hiccups after posteroventral pallidotomy have been reported in 13 patients. In seven patients after the operation there was no movement off medication, whether or not they experienced hiccups. In the rest of the patients hiccups were reported after the operation, in one of them after 1 week, in another after 2 weeks, and in the rest of the patients after 4 weeks. In this case report the patient with the most severe movements had hiccups for 2 weeks after the operation. The mechanism by which olanzapine may have beneficial effects is unclear. Olanzapine has been shown to have high affinity for a large number of receptors including D1, D2, D4, 5HT2A, 5HT2C, 5 HT3, α1-adrenergic, histamine H1, and 5 muscarinic receptors. This binding profile is similar to clozapine, another atypical antipsychotic drug, but substantially different to the conventional antipsychotic haloperidol. The preferential loss of D2 projection neurons which are involved in a feedback loop normally active in the suppression of involuntary movements is thought to be the pathological basis of chorea in patients with Huntington’s disease. The D2 antagonist properties of olanzapine may explain its possible benefits in the improvement of chorea. However, the effect at other receptors such as D4 may also be important, as D4 receptor density has been shown to be raised in Huntington’s disease. Therefore the D4/D2 ratio of activity may also be relevant. Differences in binding profile across a range of receptors may explain clinical differences in outcome when comparing different antipsychotic drugs. This case report indicates that olanzapine may be a useful addition to the treatments for movement disorder, for some patients, and controlled trials of its use in Huntington’s disease would be welcome.

### Patient characteristics

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age at surgery</th>
<th>Sex</th>
<th>Years with PD</th>
<th>H and Y*</th>
<th>UPDRS off</th>
<th>UPDRS pot</th>
<th>Pallidotomy side</th>
<th>Transient side effects</th>
<th>Medication additional to levodopa</th>
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<tbody>
<tr>
<td>1</td>
<td>66</td>
<td>M</td>
<td>8</td>
<td>2/3</td>
<td>57/NP†</td>
<td>R</td>
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<td>Tryptizol, temazepam, alprazolam, apomorphine</td>
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<tr>
<td>2</td>
<td>43</td>
<td>F</td>
<td>7</td>
<td>2/2.5</td>
<td>22/NP</td>
<td>L</td>
<td>Slight dysthria</td>
<td>Trihexifenidyl</td>
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<td>3</td>
<td>48</td>
<td>M</td>
<td>15</td>
<td>2/3</td>
<td>55/L</td>
<td>L</td>
<td>Facial paresis</td>
<td>Pergolide, amantadine</td>
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</tr>
<tr>
<td>4</td>
<td>50</td>
<td>M</td>
<td>12</td>
<td>2/2</td>
<td>45/L</td>
<td>L</td>
<td>Slight dysthria</td>
<td>Selegeline, biperiden</td>
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<tr>
<td>5</td>
<td>53</td>
<td>M</td>
<td>14</td>
<td>2/3</td>
<td>69/36</td>
<td>R</td>
<td>Facial paresis, hypophonia</td>
<td>Pergolide, selegeline</td>
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<tr>
<td>6</td>
<td>55</td>
<td>M</td>
<td>13</td>
<td>2/3</td>
<td>48/27</td>
<td>L</td>
<td>Facial paresis, aphasis</td>
<td>Selegeline, biperiden</td>
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<td>7</td>
<td>61</td>
<td>F</td>
<td>15</td>
<td>2/3</td>
<td>55/NP</td>
<td>R</td>
<td>Slight dysthria</td>
<td>Clomipazine, temazepam, cisapride</td>
<td></td>
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</table>

*H and Y=Hoehn and Yahr; †UPDRS off=unified Parkinson’s disease rating scale part 3 (motor examination), in a standardised off state, 12 hours without antiparkinson medication; NP=not performed.
localisation. Patients started with a short schedule of corticosteroids (5 days) the night before surgery.

The hiccups started immediately after the operation or the next day, were intermittent, and the bouts of hiccup of six patients, with a duration of hours, resolved within 3 days after the procedure. One patient complained of yawning more often and frequent bouts of hiccup for 6 months.

Five patients were men. All patients were right handed. The mean age at surgery was 54 years and the mean duration of Parkinson’s disease was 12 years. All patients were taking levodopa. In four patients the hiccups appeared after a left sided pallidotomy. Patient 2 had a right sided thalamotomy 4 years before the pallidotomy. Patient 5 underwent a left sided pallidotomy 10 months before the right sided pallidotomy which caused the hiccups. The pallidotomies improved parkinsonism in the “off” state (table), contralateral dyskinesias, and pain accompanying Parkinson’s disease. Six patients had transient adverse events: four patients had a transient facial paresis postoperatively and two a slight transient dysarthria (table). Two patients had choreatic movements after the pallidotomy at the contralateral side which resolved spontaneously within 2 hours and is associated with a favourable surgical outcome.

Postoperative MR scans were obtained in the first six patients, and showed that in five patients the lesions were located in the posterior part of the globus pallidus pars externa (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure). In patient 5 the lesion was situated slightly more anterior in the GPe and putamen. In patient 3 there was a small separate lesion more dorsal, probably the GPe and putamen. In patient 5 the lesions were located in the posterior limb of the internal capsule (GPe) and interna (figure).

A possible cause for the transient hiccups could be the lesion in the ventral medial segments of the globus pallidus or pressure, due to oedema, on an adjacent structure like the internal capsule or putamen. We could not find other reports of hiccups as an adverse event after functional stereotactic surgical interventions, nor after lesions of other aetiology involving the stratum. Based on our experience we hypothesise that the globus pallidus or a neighbouring structure may be involved in a supramedullary system involved in triggering hiccups.

Five months after left sided pallidotomy, MRI of patient 6: (A) transversal slice at the level of the anterior commissure and (B) 6 mm more ventral.

Psychological adjustment and self reported coping in stroke survivors with and without emotionalism

Emotionalism after stroke is common, occurring in 10%–20% of a community sample. Psychological factors in its cause or maintenance have not been studied; research has tended to concentrate instead on location of the stroke lesion. We suspect that one reason for this neglect of psychological aspects of emotionalism is that most people do not make a distinction between emotionalism, and pathological crying and laughing. As a result all disorders of emotionalism after stroke are stereotyped as being related to brain damage and therefore psychologically meaningless.

None the less, many patients with emotionalism describe their crying as provoked by emotionally congruent experiences, which makes the tearfulness seem understandable. In two previous studies we have shown that stroke patients with emotionalism have more symptoms of psychological disorder than do patients without emotionalism. In the present study, we explored further the psychological characteristics of stroke patients with emotionalism. Our aim was to determine whether they differed from patients without emotionalism in their psychological reactions to stroke, or in the coping strategies they reported.

Post-traumatic stress disorder is also characterised by recurrent episodes of intrusive and uncontrollable emotion, and we were therefore interested in whether patients with emotionalism also experienced unexpected and uncontrollable thoughts typical of post-traumatic stress disorder. Because emotionalism is often described as uncontrollable, we were interested in the possibility that patients who were more generally helpless, helpless or anxious in their responses to stroke. Again, because of the reported uncontrollability of emotionalism, we postulated that patients with emotionalism would report a more external locus of control than those without emotionalism.

Participants were adults admitted to local general hospitals after stroke, and were interviewed within 1 month of admission. Exclusions were due to poor physical health, cognitive impairment, communication difficulties, or lack of consent. Approval for the study was obtained from the local research ethics committees.

All participants completed a standardised measure of distress—the general health questionnaire, GHQ-12; a widely used measure of intrusive thoughts of the sort encountered in post-traumatic stress disorder—the impact of events rating scale; a measure of cognitive coping—the mental adjustment to stroke scale (O’Rourke S, Dennis M, MacHale S, Slattery J. The development of the mental adjustment to stroke scale: reliability, patient outcome and associations with mood and social activity, manuscript in preparation); and a measure of beliefs about responsibility for recovery from illness—the recovery locus of control scale. All the measures are self report questionnaires.

A total of 177 stroke patients were screened, of whom 112 were excluded. The 65 participants (29 men, 36 women) had a mean age of 71.8 years (range 43 to 88 years). Nineteen (29.2%) patients met our criterion for emotionalism, a rate similar to that found in other studies. Their scores on the study measures are compared with the scores of patients without emotionalism in the table.

It might be that these associations with emotionalism were accounted for by the greater general levels of distress experienced by those with emotionalism. We therefore undertook analysis of covariance with GHQ-12 and presence of emotionalism as the covariates, and each of the other test items in turn as the independent variable. The results showed an association, after adjustment for GHQ-12 score, between emotionalism and the impact of events subscales intrusion.
Comparison of stroke survivors with and without emotionalism, assessed in hospital 1 month after stroke

GHQ-12* Recovery locus of control scale Impact of events scale intrusion subscale** Impact of events scale avoidance subscale* MASS Fighting subscale MASS Anxiety preoccupation subscale** MASS Fatality subscale* MASS Avoidance subscale MASS Helplessness/hopelessness subscale**

<table>
<thead>
<tr>
<th></th>
<th>No emotionalism (n=45)</th>
<th>Emotionalism (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean (SD)</strong></td>
<td><strong>Mean (SD)</strong></td>
<td></td>
</tr>
<tr>
<td>GHQ-12*</td>
<td>3.2 (2.4)</td>
<td>5.3 (3.5)</td>
</tr>
<tr>
<td>Recovery locus of</td>
<td>33.2 (5.3)</td>
<td>34.1 (5.7)</td>
</tr>
<tr>
<td>control scale</td>
<td></td>
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<tr>
<td>Impact of events</td>
<td>2.9 (4.6)</td>
<td>9.2 (6.6)</td>
</tr>
<tr>
<td>scale intrusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subscale**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact of events</td>
<td>4.7 (4.6)</td>
<td>9.9 (6.1)</td>
</tr>
<tr>
<td>scale avoidance</td>
<td>49.1 (4.9)</td>
<td>48.6 (4.2)</td>
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<tr>
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<tr>
<td>MASS Fighting</td>
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<td>25.2 (4.0)</td>
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<tr>
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<tr>
<td>MASS Anxiety</td>
<td>20.0 (1.9)</td>
<td>21.3 (2.2)</td>
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<td>MASS Fatality</td>
<td>1.7 (0.8)</td>
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<tr>
<td>MASS Avoidance</td>
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<td>14.1 (3.5)</td>
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<tr>
<td>subscale**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MAD = Mental adjustment to stroke scale. *p<0.05, **p<0.01, t-tests.

We thank those patients who participated in the study and the staff of local hospitals and the Leeds Stroke Database for their invaluable help. We also thank Dr Louise Dye for her statistical advice. This study was completed as part of work for the degree of DClinPsych at Leeds University (SE).

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Paraneoplastic stiff limb syndrome

Stiff man syndrome (SMS) is a rare, severe progressive motor disorder characterised by painful spasms, symmetric axial muscle rigidity, and uncontrollable contractions leading to distorted posturing. The disorder has been associated with the autoantigens, glutamic acid decarboxylase (GAD), and amphiphysin, which are cytoplasmic proteins in neurons of the CNS. A large series of patients with SMS found that most have autoantibodies against GAD, whereas amphiphysin is predominantly the predominant autoantigen in paraneoplastic SMS. Recently, Barker et al presented four patients with a stiff leg syndrome marked by progressive rigidity and spasms of the lower extremities. This group of patients tested negative for anti-GAD antibody by immunoprecipitation and demonstrated distinct electrophysiologic features. By contrast, another report described two patients with stiff leg syndrome who tested positive for anti-GAD antibody. Finally, in presenting a group of 13 patients, Barker et al proposed that the nomenclature should also explore the psychological factors which might contribute to its cause or continuation.

"Stiff limb syndrome" refers to the focal form of SMS when one or more distal limbs are involved; two of their patients were also anti-GAD antibody positive, but none were tested for antibodies to amphiphysin or identified as having an underlying neoplasia. We present a patient clinically consistent with the stiff limb syndrome who was found to have autantiobody to GAD and breast cancer.

A 68 year old woman presented with a 1 month history of painful spasms in her legs. Cramps were associated with tactile stimuli and emotional upset. Within weeks, inversion began at the left and then right ankle, making ambulation difficult. Her medical history was significant for Graves’ disease treated with thionamid and radiodiary therapy, and hyperlipidaemia. She was a chronic smoker. General examination was noteworthy for lymphadenopathy in the right axilla. Her mental status was worse during periods of lower extremity spasms, during which she became anxious, diaphoretic, and tachycardic. Cranial nerve and motor evaluations were unremarkable, but assessment of the left leg, due to painful spasms elicited by light touch, was difficult. Inversion and plantar flexion were essentially fixed at the left ankle but could be overcome on the right. Deep tendon reflexes were 3+ in the upper and lower extremities, with sustained clonus at the right ankle. Sensory examination revealed the exception of hyperesthesia in the distal lower extremities, and coordination testing were grossly normal. Hyperlordosis or myoclonus was noted. Gait was limited due to ankle posturing.

The laboratory evaluation was noteworthy for a CSF with increased Ig indices (2.5, 3.4; normal, 0.2–0.8) and oligoclonal bands (5, 5) but no pleocytosis. Serological testing for anti-Hu, anti-Yo, and anti-Ri antibodies was unremarkable, and the haemoglobin A1C was 6.6 (5.6–7.7)%. Skin biopsy at three sites on the patient’s leg showed diminished epidermal nerve fibre density and terminal axonal swelling distally, consistent with a small fibre sensory neuropathy. The patient would not tolerate EMG. Magnetic resonance images of the brain and the entire spinal cord were normal. Fine needle aspiration of a soft tissue right heel raised the suspicion of metastatic adenocarcinoma. On an open surgical procedure, infiltrating duct carcinoma of the breast was identified. Anti-GAD autoantibodies were not detected by chemical assay and immunoprecipitation, but antibodies to amphiphysin were not detected by immunocytochemistry, immunoprecipitation, or western blotting (Dr P De Camilli, Yale University).

Ongoing therapy with clonazepam and a trial of oral dexamethasone did not improve the lower extremity symptoms. The patient’s ankle posturing continued a slow progression to locked inversion, with no spontaneous extension of hallucis longus. The patient died 18 months after symptom onset. Gross necropsy attributed the cause of death to aspiration pneumonia. Neuropathological evaluation showed a grossly normal spinal cord. Microscopically, the lumbar cord had mild reactive gliosis in the anterior horns but no evidence of inflammation. Sections of the frontal cortex, pons, and medulla showed mild diffuse reactive astrocytosis.

Stiff man syndrome is increasingly recognised as a heterogeneous disorder. Other case reports have documented patients with “focal” disease involving either lower or upper extremity posturing, which contrast...
with the "diffuse" axial and subsequent proximal muscle distribution of the classic disorder." Our patient differs from those reported with stiff leg syndrome in that an occult malignancy was present. Unfortunately, we were unable to obtain electrophysiological studies for comparison. The search for a paraneoplastic process was based on the findings of axillary lymphadenopathy and an abnormal CSF. Our patient is only the second reported patient with paraneoplastic SMS associated with anti-GAD antibody; the other had upper limb rigidity in the setting of breast cancer and additionally mounted an immune response to amphiphysin.

Paraneoplastic processes can affect any component of the nervous system and, occasionally, multiple levels, as in the syndrome of sensory neuropathy-encephalomyelitis. Our patient's findings were not entirely consistent with criteria for classic SMS in that an apparent encephalopathy and a small fibre neuropathy were identified—for example, her dysautonomia (tachycardia and relative hypertension) during spasms may have been a manifestation of involvement of small fibres. The role of autoantibodies in the pathogenesis of SMS and cancer is unclear. Via its probable function in endocytosis, amphiphysin has been postulated to play a part in the regulation of growth factor internalisation; however, the absence of an autoimmune response to this protein suggested by its binding to dynamin in nerve terminals, developing eventually into a comatous-like state with no spontaneous or reflexive eye opening or limb movement within 30 minutes of intubation. On neurological examination, the pupillary light reflex was absent and oculocephalic manoeuvre elicited no ocular movements. All four limbs were areflexic and Babinski's signs were absent. Brain CT and MRI findings did not suggest any intracerebral lesion.

The patient's condition kept on deteriorating, developing eventually into a coma-like state with no spontaneous or reflexive eye opening or limb movement within 30 minutes of intubation. On neurological examination, the pupillary light reflex was absent and oculocephalic manoeuvre elicited no ocular movements. All four limbs were areflexic and Babinski's signs were absent. Brain CT and laboratory studies of arterial blood gas (under assisted ventilation), electrolytes, liver function, blood glucose, and CSF study were unremarkable. An examination of renal function indicated chronic renal insufficiency with mild azotaemia (urea nitrogen 70 mg/dl, creatinine 9.1 mg/dl). An EEG, recorded 18 hours after the onset of symptoms when the neurological condition was unchanged, showed posterior dominant alpha waves intermixing with trains of short duration, diffuse theta waves. When brief noxious stimuli were applied to the sternum, they were replaced transiently by beta activities. The findings suggested that the profound neurological dysfunction might be peripheral in origin. The patient was given a course of haemodialysis according to the set schedule for uraemia at 21 hours after onset of the symptoms. Her condition improved dramatically.

Tetradotoxin intoxication in a uraemic patient

Tetradotoxin intoxication results from ingesting puffer fish or other animals containing the toxin. Clinical presentation is mainly acute motor weakness and respiratory paralysis. Death is common in the worst affected victims. Although the severity of the symptoms generally depends on the amount of toxin ingested, it may be influenced by the victim's medical condition, as described in this report. The patient was a 52 year old uraemic woman. The uraemia was of undefined aetiology. Over the past 3 years she has received regular haemodialysis. One day both she and her husband, a healthy 55 year old man, ate a fish soup. About 1 hour after the meal she developed a headache and a lingual and circumoral tingling sensation and numbness at the distal parts of all four limbs. She was dizzy and unsteady, had difficulty in swallowing, and became very weak. She was taken to the emergency service and was placed on machine assisted ventilation as respiratory distress and cyanosis developed. Her husband remained asymptomatic throughout this time.

The patient's condition kept on deteriorating, developing eventually into a coma-like state with no spontaneous or reflexive eye opening or limb movement within 30 minutes of intubation. On neurological examination, the pupillary light reflex was absent and oculocephalic manoeuvre elicited no ocular movements. All four limbs were areflexic and Babinski's signs were absent. Brain CT and laboratory studies of arterial blood gas (under assisted ventilation), electrolytes, liver function, blood glucose, and CSF study were unremarkable. An examination of renal function indicated chronic renal insufficiency with mild azotaemia (urea nitrogen 70 mg/dl, creatinine 9.1 mg/dl). An EEG, recorded 18 hours after the onset of symptoms when the neurological condition was unchanged, showed posterior dominant alpha waves intermixing with trains of short duration, diffuse theta waves. When brief noxious stimuli were applied to the sternum, they were replaced transiently by beta activities. The findings suggested that the profound neurological dysfunction might be peripheral in origin. The patient was given a course of haemodialysis according to the set schedule for uraemia at 21 hours after onset of the symptoms. Her condition improved dramatically.
Critical illness polyneuropathy
Axonal Guillain-Barré syndrome

Relation between critical illness polyneuropathy and axonal Guillain-Barré syndrome

The clinical entity critical illness polyneuropathy occurs almost exclusively in patients in critical care units and has been characterised as a complication of sepsis and multiple organ failure.1 Critical illness polyneuropathy may be a common cause of the difficulty in weaning patients from the ventilator, particularly those who show intractable ventilator dependence. All the measures used to prevent respiratory failure are not enough, and the patient retained consciousness when the symptoms were at their most severe.

One of the most striking clinical features in our patient was the response to haemodilysis. Despite a small amount of toxin ingested, the dramatic improvement of her clinical condition was most likely attributed to the rapid elimination of absorbed toxin in the course of haemodialysis, rather than spontaneous recovery. The physical and chemical properties of tetrodotoxin are also supportive to this hypothesis.1 It has a low molecular weight (C11H17N3O8), is water soluble, and not significantly bound to protein—all these features are often found in toxins amenable to haemodialysis. Traditionally, the management of tetrodotoxin intoxication is mainly supportive, such as gastric lavage to remove unabsorbed toxin and machine assisted ventilation when respiratory is severely affected. We suggest that haemodialysis may be an effective method in the treatment of tetrodotoxin intoxication.

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of acute diarrhoea, commonly precedes the development of Guillain-Barré syndrome. There is a close association between axonal Guillain-Barré syndrome and antecedent C. jejuni infection. The antecedent infectious symptom was diarrhea in three of five patients with axonal Guillain-Barré syndrome described by Feasby et al. Observations by Griffin et al confirmed that AMSAN follows C. jejuni infection. Serum samples from patients with axonal Guillain-Barré syndrome subsequent to C. jejuni enteritis often have the same class autoantibodies to gangliosides GM1, GM1b, GD1a, or GalNAc-GD1a in the acute phase of the illness, and there is molecular mimicry between these gangliosides and the lipopolysaccharides of C. jejuni isolates from patients with Guillain-Barré syndrome. This ganglioside mimicry may trigger high production of the IgG anti-ganglioside antibodies, and these autoantibodies may cause motor nerve dysfunction in patients with GBS.

Interestingly, Hagenesse et al reported a case of “C. jejuni bacteremia and subsequent Guillain-Barré syndrome” that occurred in a patient with chronic graft versus host disease and total body irradiation prior to bone marrow transplantation. Because there was acute flaccid paralysis associated with sepsis, some physicians might have diagnosed critical illness polyneuropathy. Conversely, the existence of this case strongly suggests that some diagnoses of critical illness polyneuropathy should actually be axonal Guillain-Barré syndrome or AMSAN. Our hypothesis of the nosological relation between critical illness polyneuropathy and Guillain-Barré syndrome is shown in the figure. Serum IgG antibodies against GM1, GM1b, GD1a, or GalNAc-GD1a could be used as immunological markers for axonal Guillain-Barré syndrome. To examine the aetiology of critical illness polyneuropathy and its nosological relation to axonal Guillain-Barré syndrome, it is necessary to investigate whether patients with critical illness polyneuropathy have anti-ganglioside antibodies during the acute phase of the illness.

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Repetitive transcranial magnetic stimulation in the treatment of chronic negative schizophrenia: a pilot study

Recently, a new technology known as repetitive transcranial magnetic stimulation (RTMS) has been developed. In 1994, the use of magnetic stimulation in clinical psychiatry was suggested. Since then, it has been used in the study or treatment of obsessive-compulsive disorder, conversion disorder, schizophrenia, and particularly, depression.

Our pilot study aimed to assess the possible adverse effects of this treatment in chronic schizophrenic patients with severe negative symptoms; to evaluate if direct RTMS of the prefrontal cortex might improve negative symptoms or cognitive impairments in patients with chronic schizophrenia; and thirdly, to note if RTMS might modify the deficit in prefrontal cortical activity, often referred to in established chronic schizophrenia, specially under conditions of task activation.

Six right handed patients with chronic schizophrenia were identified at the outpatient psychiatric hospital of the Hospital Clinic of Barcelona. There were two men and four women (mean age 39).

Exclusion criteria included alcohol or substance abuse dependence disorder in the past 5 years, focal neurological signs, systemic neurological illness, taking cephalic mediator as well as anti-convulsant therapy within 6 months, and significant abnormal findings on laboratory examination.

All patients were taking neuroleptic drugs, but a stable dose for at least 3 months was required. All patients were studied off benzodiazepines for at least 1 week before beginning the treatment. During the RTMS, psychotropic medications were continued at the initial dosage.

All patients were admitted to hospital. Inpatients underwent the UKU side effect scores,1 the positive and negative syndrome scale (PANSS), and a neuropsychological battery, the day before beginning the treatment and at the end of the treatment. The UKU scale was also administered after each session.

An equivalent neuropsychological battery was used on both occasions, which consisted of the block design task of the Wechsler adult intelligence scale, the trail making tests A and B, the FAS verbal fluency test, and two subtests of the Wechsler memory scale (the visual memory reproduction and the verbal paired associates subtests).

A brain SPECT study was performed using a rotating dual head gamma camera, fitted with high resolution fanbeam collimators. Two gamma-HMPAO SPECT scans with cognitive activation, such as the Wisconsin card sorting test (WCST), were performed on each patient (24 hours before the beginning of the treatment and 24 hours after the last session).

RTMS was given with a Mag Pro magnetic stimulator, 5 days a week, during 2 weeks, at the last session).

RTMS was given with a Mag Pro magnetic stimulator, 5 days a week, during 2 weeks, at a dosage of 20 Hz for 2 seconds, once per minute for 20 minutes at 80% motor threshold. The motor threshold was determined by visualisation of finger movement. A butterfly magnetic coil was placed tangential to the orbital area, on the C3 and C4 EEG point.

An important finding of this study was that RTMS may be given to stable schizophrenic patients without exacerbating their psychopathology. However, significance was not achieved in our conclusions, it is certain that there has been an improvement in the attentional capability. We found that all patients (except one, who was always within the normal range) diminished their number of perseverative answers and errors on WCST (items characteristically altered in schizophrenia) after the RTMS. However, significance was not achieved on any WCST scores.

Two patients who initially did not perform any categories on WCST, after the treatment, achieved one category, a possible indication of improvement of the working memory. This, along with other methodological limitations regarding the power of our conclusions, is it certain that there has been an improvement in the attentional capability.

We found that all patients tolerated the RTMS well, with minimal side effects (mild headache and tinnitus).

Critical SPECT of one patient was reported to be normal, showing no evidence of hypofrontality. The remainder of the patients showed hypofrontality on the initial neuromaging. The results after RTMS indicated no change in the hypofrontality.

Negative symptoms showed a general decrease for all patients (table). Significance (p<0.02) was noted on the PANSS negative symptoms subscale. These patients seemed to be more sociable than when originally seen. Nevertheless, clinical effects of the RTMS were subtle and difficult to distinguish from those derived from the supportive environment of the psychiatric ward.

With regard to the neuropsychological battery, we found a general improvement in all post-treatment scores (table), but only delayed visual memory achieved significance (p<0.05). This feature might be basically explained by improvement of attention, specifically of the maintenance of attention, which allows the correct function of the working memory. The absence of any hypofrontality, or methodological limitations regarding the power of our conclusions, is it certain that there has been an improvement in the attentional capability.

We found that all patients (except one, who was always within the normal range) diminished their number of perseverative answers and errors on WCST (items characteristically altered in schizophrenia) after the RTMS. However, significance was not achieved on any WCST scores.

Two patients who initially did not perform any categories on WCST, after the treatment, achieved one category, a possible indication of improvement of the working memory. This change leads us to consider a research strategy previously reported, in which the WCST is used as a screening test for selecting schizophrenic patients. Those initially achieving low category scores would be compared to higher category scorers in an effort to identify a subgroup most likely to benefit from RTMS.

Taking into account these mild improvements together, and the lack of changes in

Table 1  Neuropsychological tests and PANSS scores

<table>
<thead>
<tr>
<th>Test</th>
<th>Mean (SD)</th>
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</thead>
<tbody>
<tr>
<td>Block design</td>
<td>Pre 49 (11.9) NS</td>
</tr>
<tr>
<td>Trail making test A</td>
<td>Pre 38 (6.9) NS</td>
</tr>
<tr>
<td>Trail making test B</td>
<td>Pre 38 (5.4) NS</td>
</tr>
<tr>
<td>Immediate visual reproduction</td>
<td>Pre 38 (5.4) NS</td>
</tr>
<tr>
<td>Delayed visual reproduction</td>
<td>Pre 36.5 (11.9) p&lt;0.05</td>
</tr>
<tr>
<td>Immediate verbal paired associates</td>
<td>Pre 54 (7.6) NS</td>
</tr>
<tr>
<td>Delayed verbal paired associates</td>
<td>Pre 59.5 (10.03) NS</td>
</tr>
<tr>
<td>PANSS-PG</td>
<td>Pre 8.8 (1.17)</td>
</tr>
<tr>
<td>PANSS-N</td>
<td>Pre 37.67 (11.15) NS</td>
</tr>
<tr>
<td>PANSS-P</td>
<td>Pre 36.5 (11.47)</td>
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<tr>
<td>PANSS</td>
<td>Pre 31.67 (8.26) p&lt;0.02</td>
</tr>
<tr>
<td>PANSS-P</td>
<td>Pre 27.83 (8.47)</td>
</tr>
<tr>
<td>PANSS-P</td>
<td>Pre 16.83 (7.28) NS</td>
</tr>
<tr>
<td>PANSS-P</td>
<td>Post 15.33 (7.55)</td>
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</tbody>
</table>

Pre=treatment; Post=post-treatment; PANSS= positive and negative scale; PG=general psychopathology scale; N=negative scale; P=positive scale.
Sensory alien hand syndrome

The case report by Ay et al. of alien hand syndrome and review of the literature neglected the intriguing issue of why in every case so far reported the patient seems to be terrified of the alien limb. Not believing that you are any more in control of a limb is not likely to be a pleasant experience.

Those with alien hand syndrome seem to jump to extremely negative conclusions concerning the intent of the limb. Typically, in the report of Ay et al. at least the common belief is that the limb has deeply malevolent intentions towards the victim.

It is this aspect of alien hand syndrome that I suggest also needs incorporating into its neurological explanations, and which provides a clue as to why our everyday experience of being in charge of our bodies, and so initiating all personal action, itself has a neurological basis. In other words, while the brain is the source of our conscious perceptions and experiences, there is also a part of our nervous system which is responsible for our belief that we have free will over our behaviour. Patients with alien hand syndrome think that they are no longer in control of a limb because the part of the brain that gives us the sensation of control over our bodies has been damaged. When that happens, our limbs seem to act independently of us.

Research conducted in the 1980s has found that the same electrical brain wave changes that characterize predittomally precede all limb movements, occur several 100 ms before we seem to consciously decide to move a limb. If our conscious decision to act preceded by brain changes that anticipate action, then our “decision” to choose how to behave or “freedom”, as in free will, is in fact illusory. Our choices have in a sense been decided beforehand by our brains.

Spence’ asserts that evidence such as this, combined with phenomena such as alien hand syndrome, means that philosophers have to reconsider whether we have free will. He argues that these data suggest that our sense of agency is illusory and it follows that most of us share in common the useful delusion that we have free will. Patients with alien hand syndrome have lost this experience in relation to a particular limb. There is a sense then that those who experience the syndrome are closer to the reality of how much we are responsible for our actions than the rest of us. This is because a feature of the function of the part of the brain that normally works to make us think that we have conscious freedom of will. They develop the experience, therefore, of becoming mere remote spectators to the actions of their bodies.

Defenders of human “free will” argue what happens before the brain itself decides to act is still unknown, and there may be a role for our own autonomy there. But even these free will guardians concede the neurological research indicates that whatever happens before the brain is roused, must occur below our conscious awareness.

Yet in alien hand syndrome the patient thinks that the hand has hostile motivations; it is invariably the case that the patient not only thinks that the limb is “not self” but finds that the limb behaves towards the self in a destructive and aggressive manner. This could be explained by the suggestion that if we lose our conscious sense of voluntary control over our bodies, our minds have to come up with an explanation for the location of our actions. We decide that if ourselves are not in control, then someone or something else must be; therefore, we no longer have a sense of the limb belonging to us.

Because to lose control over our bodies is one of the most terrifying experiences, our attempt to explain this finding occurs in the context of fear. It may be that our apprehension leads us to misinterpret innocent reflexive acts of our hands, such as scratching or rubbing, as malevolently inspired. Plus it could be that our interpretation of spurious possession in turn is what gives rise to the belief that only this is beyond our conscious awareness.

It may therefore be that we need to believe in our own free will and personal control over our limbs, because if we did not, the experience of our bodies acting as if we merely came along for the ride, too frightening. Also, we may no longer believe that our bodies or its relevant parts belong to us. All neurologists who have reported alien hand syndrome remark on how psychologically disturbing the symptom is for the patient. Psychiatrists would be interested in the parallels between alien hand syndrome and the schizophrenia. So the fact that every case, plus the fact that the two diseases may share corpus callosum pathology, could some way to explaining why schizophrenic symptoms are frightening to the patient. So it seems we know that our limbs belong to us because they obey us. When they seem to stop responding to our wills, we conclude that our limbs are no longer our own, and try to fend them off. Hence it would seem that one of the prices we had to pay for conscious awareness of ourselves to evolve as a function of the brain, is the delusion that we are responsible for all our actions. If we had conscious awareness of ourselves, but no sense of free will, our bodies would feel alien to us.

The philosophical importance of alien hand syndrome is that it shows emphatically via neurology that it is possible to drive a wedge between consciousness and the experience of free will. The brain had to develop the sensation of free will after developing consciousness, because being without the sensation of free will produces extremely negative emotional experiences. So the fact that every case, so far reported of alien hand syndrome imputes negative intent to the alien limb might not be an incidental finding, but a core aspect of the disorder.

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The authors reply:

We appreciate Persaud’s comments regarding the alien hand syndrome, “the perceived malevolence of the affected limb towards its victim, and the question of whether with loss of the conscious sense of voluntary control over our bodies, our minds... decide that if ourselves are not in control then someone or something else must be”. We would offer that the value of our particular case is that it was due to a central deafferentation—therefore the term “sensory alien hand syndrome”. As
opposed to the idea that “we know our limbs belong to us because they obey us”, we know that our limbs belong to us because they provide us with sensory input that is recognised as self. Many patients with movement disorders or paralysis lose control of their limbs but still have no difficulty in realising them as self. Indeed even in “phantom limb” there is sense of self due to central processes in the absence of a limb. Our patient, as do others with anosognosia and primary abnormalities of central sensory systems, shows perhaps that it is central sensory processes that are the key to identifying “self”. We know our limbs not because they obey us but because of a pattern of sensory sensation that accompanies our own limb movements. When this pattern never reaches specific cortical regions, then the limb is not perceived as self; called “amorphogenesis” by Denny-Brown and Banker. Sensory stimulation by the centrally deafferented limb in “sensory” or “posterior” alien hand syndrome, or kinaesthetic stimuli due to movement of the limb as in the “anterior” or “motor” alien hand syndrome, is perceived as due to another person or thing without critical questioning. This raises the most interesting question of what brain region is deafferented in the anterior alien hand syndrome whereas sensory processing is intact.

It is not our clinical experience nor the conclusions based on published reports that all patients suffering with alien hand syndrome are deafferented by the affected limb. In one author’s experience (BHP), two patients with alien hand syndrome and related intermanual conflict were irritated by but not terrified by their opposing limbs simultaneously. One patient, who believed the other patient was amused but rather indifferent to his affected left side. The most terrifying situation we have heard is when the patient identified his affected left side as belonging to his mother in law and patient. An almond shaped region by Heilman’s group with persistent alien hand syndrome referred to it as “my little sister”. Similar to our experience, they suggest that a particular personality type may be necessary given that most patients with collosal infarcts or tumours do not emphasise this complaint.

Unlike our case of limited duration, the persistence of alien hand syndrome is a problem dependent on mesial frontal dysfunction. These patients rarely deny that the affected limb belongs to them. Instead, they understand it in terms of their “anarchic hand”. Hence, although the initial syndrome may result in disjointed and terrifying perceptions, it seems that the brain quickly re-establishes its control by presently unknown adaptive capacities. Furthermore, why it almost exclusively involves the left body side in right handed people remains unknown. Studying this syndrome in greater detail may yield additional insights into the pathophysiology of denial and misidentification.

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**Vasomotor reactivity is exhausted in transient ischaemic attacks with limb shaking**

The article of Baumgartner and Baumgartner entitled “Vasomotor reactivity is exhausted in transient ischaemic attacks with limb shaking”1 provides interesting new information regarding the possibility that involuntary limb movements contralateral to haemodynamic failure from severe carotid artery occlusive disease. The authors evoke an “exhausted cerebral vasoreactivity in the hemispheres opposite the involuntary limb movements”2. In their report, involuntary movements affected only the limbs, and displayed no tonic contraction, tonic-clonic jerking, or Jacksonian march and no epileptic activity during attacks. These findings led the authors to strongly argue against seizures as the cause of limb shaking in these transient ischaemic events.

In contradistinction, a 72 year old right handed man was admitted to our hospital with a 3 month history of episodic weakness and numbness of the right arm. The patient then had six discrete stereotypic episodes of right arm weakness and clumsiness that were also associated with limb shaking in speaking. Several episodes of dysarthria, numbness and weakness of the right arm and leg (MRC grade 4/5) were seen, unrelated to posture, some of which occurred when the patient was supine. Most of the episodes were characterised by slight tremulousness and asterixis-like movements of the outstretched right arm. There was a return to baseline functioning between events.3 Video/EEG monitoring, however, showed low voltage spikes in the left central-parietal head regions contralateral to the facial twitching and the right arm and right leg weakness. Although ongoing clinical and EEG seizures activity stopped after 2 mg intravenous lorazepam, they reoccurred after loading with phenytoin. Because angiography disclosed a greater than 95% stenosis of the left internal carotid artery (while the patient was treated with phenytoin at a concentration of 16.5 mg/l), the patient was anticoagulated with heparin, but episodes continued. It was only after a left carotid endarterectomy that all episodes stopped, tremulousness, and EEG asterixis activity stopped. They have not recurred over the past 5 years.

The literature includes several cases of focal motor inhibitory seizures causing weakness.4 Although it is impossible to prove a negative, it could be argued that although no epileptiform or other evidence of seizure activity is present in a particular case, the abolition of ongoing clinical and EEG evidence of inhibitory motor activity by intravenous diazepam argues in favour, at least in part, of an ictal contribution. The fact that in virtually all reported cases, abnormal movements are more definitively resolved by carotid endarterectomy argues for an underlying ischaemic aetiology that induces focal seizures. There are few reports that clearly delineate the interaction and association of inhibitory focal motor seizures and transient ischaemic attacks, as there are few sequential trials of antiepileptic drugs or anticoagulation (under EEG monitoring) and finally carotid endarterectomy. Several authors support the concept of an inhibition of motor function in parietal and secondary somatosensory re- LIGNOS BY SEIZURE ACTIVITY WHICH THEN INTER- RUPT THE SENSORY FEEDBACK LOOP TO MOTOR INTEGRATION WITH INHIBITION OF SUBCORTICAL AND SUBCORTICAL AREAS.5 PETER W KAPLAN Department of Neurology, University Hospital of Zurich, Switzerland

1 Baumgartner RW, Baumgartner L. Vasomotor reactivity is exhausted in transient ischaemic attacks with limb shaking. J Neurol Neurosurg Psychiatry 1998;65:561-4.

Baumgartner and Baumgartner reply: We are grateful for the response of Kaplan to our short report. We agree that somatic inhibitory seizures may mimic transient ischaemic attacks (TIAs). Such TIAs are associated with negative symptoms such as sensorimotor deficits and difficulty with speaking, EEG evidence of seizure activity, and cessation of the TIAs after the administration of an anticonvulsant drug.1,2 Limb shaking TIAs, however, differ from TIAs related to inhibitory seizures in several ways. (1) They are associated with positive phenomena (limb shaking), and the involuntary movements do not affect the facial muscles. (2) Patients with attacks of shaking movements of the limbs have no EEG evidence of epileptic activity, and involuntary movements do not stop after administration of anticonvulsant therapy. (3) Although the patient pre- sented by Kaplan had a 95% stenosis of the left internal carotid artery, it is unclear whether haemodynamic failure was present or not, because no studies evaluating the haemodynamic reserve of the homolateral hemisphere were presented. This is in accordance with the finding that the involuntary movements as well as the sensorimotor deficits of Kaplan’s patient were not related to paresis.4 The pathoanatomical mechanisms may be due to disinhibition of subcortical control mechanisms as a result of ischaemia.

In our opinion, it is not clear whether the asterixis-like movements of the outstretched right arm of Kaplan’s patient are due to epileptic seizures, because unilateral asterixis of the outstretched arm has been reported with contralateral vascular lesions affecting almost all cerebral structures, including the homolateral hemisphere including the territory of the middle cerebral artery.1

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1 Kaplan PW. Focal seizures resembling transient ischaemic attacks due to subclinical ischemia. Cerebrovasc Di 1993:8:241-3.
BOOK REVIEWS


To the MRCP candidate neurology is one of the more daunting specialties. The unfamiliar nerve conduction study and the frankly mysterious EEG can distress an otherwise well rounded junior house officer. Despite the fact that much of neurology is commonly seen on a general medical ward—strokes, dementia, and so forth—the general perception is of an unimaginable list of eponymous syndromes and obscure signs. Rather than dwell on the last, in this book Dr Smith tries to address the commoner complaints as examination style questions each with a “simple clinical lesion”. The “grey cases” section, for instance, includes questions on multiple sclerosis, cluster headache, and HSV encephalitis, while broadening the topics to include postinfective demyelination, chronic herniation, and acute haemorrhagic encephalitis. There is, however, a tendency for the discussion after each question to be rather brief. A fuller explanation, with more allowance for the reader’s ignorance, would have been appreciated. The data interpretation section is somewhat better, covering CSF, EEG, and other data extremely well. Perhaps a little too well; would an MRCP candidate really be expected to recognise the characteristic EEG of Creutzfeldt-Jakob disease? I surely hope not. Finally, the slide tests are disappointing. If anything, neurology lends itself best to this section of the written examination but it is let down by the poor quality of some of the images in this book. This is especially unfortunate, as other images in the same section are remarkably impressive. The Sturge-Weber skull radiograph and central pontine myelinolysis MRI are beautiful. In summary, this is a creditable first edition. I look forward to the second.

STEFAN MARGNIK


This book, after a short introduction to some of the fundamental features of the disease goes on to provide some 117 illustrations of aspects of the histopathology of the disease as seen in the cerebrum, cerebellum, and midbrain. The illustrations are very comprehensive, covering all aspects of the disease from the earliest changes to the advanced disease. The book is well illustrated with high quality photographic images and diagrams. The book is divided into five parts, each covering a different aspect of the disease. The first part covers the histopathological changes, the second part covers the clinical features, the third part covers the imaging features, the fourth part covers the treatment and management of the disease, and the fifth part covers the research and future directions. The book is well written and is a valuable resource for anyone interested in multiple sclerosis.

ROBERT MACFARLANE


Transcranial colour duplex sonography is an ultrasound technique which is becoming increasingly available for the non-invasive imaging of intracranial structures, particularly the basal cerebral arteries. There are now four principal components to the technique: B mode ultrasound which can be used to image the brain parenchyma; colour coded Doppler which provides a colour image of the basal vessels; spectral analysis of pulsed wave Doppler which is used to derive blood flow velocities; and latterly “power” Doppler which is used to create a grey scale image of the blood flow. The main advantage of this technique is that it is non-invasive and can be used to image the brain in real time. The main disadvantage is that it is less sensitive than invasive techniques such as angiography. This book is a comprehensive review of the current state of the art in transcranial colour duplex sonography. It is divided into five parts, each covering a different aspect of the technique. The first part covers the technical aspects, the second part covers the clinical applications, the third part covers the research and future directions, the fourth part covers the quality assurance and quality control, and the fifth part covers the practical aspects of the technique. The book is well written and is a valuable resource for anyone interested in the technique.
introduction setting the scene for the five main disease sections covering developmental/genetic disease, spinal injury, infection, tumour, and the effect of neurological and systemic disease on the spinal cord. This chapter covers a wide area from multiple sclerosis to motor neuron disease to vascular disease to metabolic diseases. Then follows a section on investigation considering imaging, neurophysiology, and urodynamics. Finally, there is a miscellaneous section covering clinically important entities such as pain, sexual problems, and terminal care associated with spinal cord disease but also including a highly specialised chapter on the role of oesophageal transfer in spinal cord injury.

This is an ambitious attempt at being comprehensive. The editors themselves worry that the emphasis favours surgical conditions. Although this might be the case, many surgeons belong to the neurological or rheumatologist, care for spinal disease often falling between several specialties. Therefore, it is of benefit to the clinician to have all aspects of spinal disease in one volume. The standard and style of the individual chapters varies, that on motor neuron disease being up to date and topical, malignancies being covered in depth. That on sexual problems associated with spinal cord disease is excellent and particularly practical and a must for both doctors dealing with spinal disease and for patients themselves who are often uninformd (our fault, not theirs). The chapter on depresssion illness will be good for thought for many doctors who enjoy recreational diving, for although studies have not yet shown adverse affects on the quality of life in those who dive frequently but not with incident, the incidence for cumulative neurological damage from neurophysiological, imaging, and pathological studies is compelling.

The quality of illustration is high. Perhaps not surprisingly, this is particularly evident in the imaging section (where there is a rather spectacular sagittal T2 weighted MRI of a intramedullary arteriovenous malformation). In addition to imaging many of the chapters also make good use of schematic diagrams and line drawings to enhance the text.

Drs Engler, Cole, and Merton end their preface by commenting that “Our main hope, however, is that the chapters will read as a series of views on the spinal cord and its disease, so that a surgeon may learn about current practice as well as the wide range of conditions aecting the cord that are outside the field of surgery”. While I agree that educating surgeons is an admirable aim, I think that the authors rather undersell themselves and that this book’s main strength, as I have said above, is that it will appeal to all disciplines that deal with spinal cord disease, bringing together neurological, rheumatological, and surgical disease that is often covered in separate textbooks.

GILLIAN HALL


This is the second time that I have been asked to review a book on this topic. The first time I approached the task with some scepticism - were neurological diseases in women really so different from those in men that they warranted their own text book? But I rapidly became a convert to the cause, being reminded that there are issues specific to females that influence both disease, investigation, and treatment (pregnancy, breast feeding, menopause, to name the most obvious) and that not all neurological diseases attack the sexes equally. There are also wider socio-economic and legal issues that play a part in the complete disease picture which many of us neglect too often but which this book is careful to address (see below). Leaving content aside for a moment, this is a beautifully presented book; clearly headed and with wide use of well constructed tables. It encourages one to read on. It seems up to date and well referenced.

The contributors (40 in total) are exclusively American, and east coast American at that with only occasional forays westward. The text is divided into three sections. The first, entitled General Disease in Women includes an anatomical chapter considering the sex differences of regional brain structure and function. More novel for this type of text, it contains two thoughtful chapters considering women’s health within the context of their lifestyles and women’s health and its relation with the law. This chapter considers issues such as coercive approaches to preventing foetal harm, those relating to informed consent to medical treatment, and difficult choices with neurological implications. The law and the case examples are exclusively American but the issues are universal. This opening section leaves no doubt that this is a book that has taken female issues extremely seriously.

The second section looks at neurological diseases as they affect females at different life stages, from birth through menarche, pregnancy, and menopause, to the elderly woman. As well as considering genetic diseases that strike at a particular age, these chapters consider the influence of changing physiology and hormonal balance on neurological disease. The third section is the most conventional. Each chapter considers a neurological disease representing these diseases with emphasis on their effect on women and there is, by necessity, some overlap between this and the previous section. As a non-American, I would feel more comfortable to believe that the high number of female patients with peripheral nerve injuries secondary to physical beatings, knife wounds, or gunshot wounds reflected the country of origin of this book.

If pushed to criticise, the indexing could be more complete and certain conditions considered in more detail, in particular, paraneoplastic conditions associated with breast and gynaecological malignancies. However, that aside, I think this a rather special book and not only a good addition to any neurological library but a useful purchase for anyone interested in female medical issues.

GILLIAN HALL

The reader may be interested in the following:


CORRECTION


During the editorial process the descriptions of the histograms in figure 4 (p 614) were wrongly ascribed. The corrected figure is reproduced below.