Assessment and treatment of dizziness

“There can be few physicians so dedicated to their art that they do not experience a slight decline in spirits when they learn that their patient’s complaint is giddiness. This frequently means that after exhaustive enquiry it will still not be entirely clear what it is that the patient feels wrong and even less so why he feels it.”


These words are not quite as true today as when Bryan Matthews wrote them nearly 40 years ago. There is now cause for cautious optimism. Recent clinical and scientific developments in the study of the vestibular system have made the clinician’s task a little easier. We now know more about the diagnosis and even the treatment of conditions such as benign paroxysmal positioning vertigo, Menière’s disease, acute vestibular neuritis, migrainous vertigo, and bilateral vestibulopathy than we did in 1963 and our purpose here is to introduce the clinician to facts worth knowing.

(A) The patient who has repeated attacks of vertigo, but is seen while well

"Doctor I get dizzy". This is of course one of the most common problems encountered in office practice and the one to which Matthews was alluding. The clinician’s first job is to sort out whether the dizzy patient is having attacks of vertigo, or attacks of some other paroxysmal symptom. So what is vertigo and what are its mechanisms and clinical characteristics?

The first point about vertigo is that it is an illusion of rotation and that it is always due to asymmetry of neural activity between the left and right vestibular nuclei. This is true whether the vertigo is induced by being spun around and then suddenly stopped, whether it is induced by having cold water squirited in one ear, whether it is induced by otocomial particles rumbling up and down a semicircular canal duct, or whether it is induced by infarction of one vestibular nucleus. The second point is that vertigo is always temporary. Even after the vestibular nerve on one side has been surgically severed, the terrible vertigo and nystagmus that follow will always abate within a few days, not because the vestibular nerves have reanastomosed but because profound neurochemical changes have taken place in the brainstem during the process of vestibular compensation.

The third point is that vertigo is always made worse by head movement, just as angina is always made worse by exertion. If you don’t believe this, then try the following: spin yourself around about 10 times (standing or sitting, it doesn’t matter) and then stop and throw your head backwards, quickly.

Convinced? One can be reasonably sure then that the patient who is happy to move around while dizzy does not have vertigo, and that the patient who is dizzy all the time and whose dizziness is not made better by keeping still, either hasn’t got vertigo or hasn’t got the story right. Now that we are sure that our patient has vertigo the next question to answer is whether the vertigo attacks are spontaneous or positional. But before we go on to answer that let us consider briefly the diagnosis of other common paroxysmal disorders such as syncope, seizure, hypoglycaemia, and hyperventilation.

Obviously patients with aural vertigo should not lose consciousness but it is surprising how few people can give a confident and convincing answer to the simple question: “Did it feel like you were losing your balance or like you were losing consciousness? Did it feel like you were going to pass out or fall over?” Patients with vertigo might actually lose consciousness if they have been vomiting a lot, or if they had an otolithic drop attack and a head injury on the way down. Witness descriptions are not much help in identifying vertigo, but can be essential in identifying seizures and syncope. (Convulsive syncope is of course more complicated.) Tilt table testing, particularly with lots of invasive instrumentation, is, according to some, too sensitive and insufficiently specific to help much with the diagnosis of vasovagal (now renamed “neurocardiogenic”) syncope.1 2 Cardiac syncope can, particularly in a patient without heart disease, be a difficult diagnosis. An event monitor which the patient wears for several weeks is more useful, particularly for picking up intermittent heart block, than a 24 hour Holter monitor which is best at disclosing the asymptomatic arrhythmias. A cardiac electrophysiological study is good at picking up the sort of tachyarrhythmias that can cause syncope and is less irksome than an endless sequence of inconclusive indirect investigations. Video-EEG monitoring has proved helpful in the diagnosis of seizures but is not easily available to everyone. Measurement of blood glucose during an attack, possible with a finger-prick glucometer, is the easiest and most direct way to make the diagnosis of hypoglycaemia, something that is easy to miss in the patient who is not being treated for diabetes.

Whereas panic attacks, especially with hyperventilation, commonly cause a sense of dizziness that is not actually
vertigo, patients with recurrent undiagnosed vertigo can develop panic attacks particularly if the vertigo attacks are reassuringly put down to “... just a little anxiety”. This is one of those unusual situations in which patients do as they are told: they go on to develop anxiety, panic, and even agoraphobia. "Phobic postural vertigo" is a variant of this problem in which patients, often with obsessive-compulsive personalities, complain of a mild subjective disturbance of balance while standing or walking, with momentary illusions of motion. The symptoms usually occur in specific places or in specific situations, and are associated with a distressing anxiety. Many cases follow a clear, well documented peripheral vestibulopathy. Not everyone likes the name “phobic postural vertigo”, although we all see these patients, and typically they do well with simple non-judgmental support and an accurate non-patronising explanation.

BENIGN PAROXYSMAL POSITIONING VERTIGO (BPPV)

Benign paroxysmal positioning vertigo (BPPV) is the single most common cause of vertigo seen in office practice and many patients give a story that is clear enough for a telephone diagnosis. “Doctor, whenever I turn in bed at night, or I hang the washing on the line or look under my car...” They don’t even have to say that they are dizzy! In most patients the BPPV will occur in bouts lasting several weeks and will then spontaneously remit, only to return weeks, months, or even years later. The patient with repeated bouts of vertigo over several decades with no abnormalities on examination, has BPPV. Recently, it has become clear that the cause of BPPV is the movement of stray otoconial particles within the duct of the posterior semicircular canal and that it is possible to remove these and so to put the patient into immediate remission basically by rolling the patient slowly by 180 degrees, from the most provocative position towards the normal side.

The positioning test, as described by Bárány, perfected by Dix and popularised by Hallpike, is the cornerstone of diagnosis and now of treatment. The idea of the test is to make any otoconia in the posterior semicircular canal move and so provoke vertigo and nystagmus. Eventually Brandt and Daroff and then Semont et al and Epley realised that making the otoconia move within the duct also allows them to be removed from the duct. But if you can’t provoke the BPPV, you can’t fix it.

Consider a patient with left posterior semicircular canal BPPV, seated on a bed. In this position the posterior semicircular canal is gravitationally vertical, and its ampulla is its lowermost part; any otoconia in the duct will have come to rest next to the cupula (fig 1-start). The patient’s head is now turned to the left and the patient is suddenly pitched backwards (in the plane of the posterior semicircular canal) until the head is hanging over the end of the bed so that the lowermost point becomes the midpoint of the posterior semicircular canal duct rather than the ampulla. The otoconia will now fall down from the cupula and come to rest at the midpoint of the duct. As they fall away from the cupula they create a negative fluid pressure and so pull on
the cupula producing an ampullofugal deflection which is
excitatory for primary afferents of the posterior semicircu-
lar canal. As a result there is not only a brief—20 seconds
or so—paroxysm of vertigo, but also of a nystagmus with
upbeating and counterclockwise fast phases—from
the patient's point of view.10 That is, the rotation axis of
the nystagmus is at 90 degrees to the plane of the stimulated
semicircular canal, in this case the left posterior canal. If
the patient is now slowly rotated by 180 degrees in towards
his right, until the right side of his face is touching the bed,
the posterior semicircular canal will have been inverted
(fig 1 F) so that the common crus, which joins the anterior
and posterior semicircular canals, is now the lowermost
point. At this stage the otoconia should move further along
the semicircular canal duct and produce another, but this
time less severe, paroxysm of vertigo and of counterclock-
wise upbeating nystagmus. The patient, still face down,
now stands up and the otoconia will continue along the
common crus back into the vestibule. This is in essence the
particle repositioning or perhaps better termed “libera-
tory” manoeuvre as described by Epley. It will stop the
BPPV attacks in about four out of five patients.11 Those
who are resistant to repeated repositioning manoeuvres can
be cured by surgical occlusion of the posterior semicircular
canal.12 Post-traumatic cases in particular can be bilateral
but it is sometimes difficult to tell bilateral BPPV from
unilateral BPPV with a vigorous off direction (ampullo-
petal) nystagmus on turning toward the unaffected side.13
In most patients with BPPV there are no other
symptoms and there is no demonstrable abnormality of
vestibular or auditory function. In a few it follows acute
vestibular neuritis or occurs during the course of a
progressive inner ear disease (for example, Menière's
disease, Cogan's syndrome). Very rarely is a clinical picture
identical to typical BPPV produced by a posterior fossa
problem such as a tumour, malformation, or degeneration
and BPPV is common enough for a patient to have both.
Lateral semicircular canal BPPV is a variant first
described by Pagnini et al and by McClure in which the
nystagmus is horizontal and usually beats toward the low-
ernest ear indicating that the otoconia in the duct are fall-
ing toward the cupula.14 The discovery of the existence
and then of the mechanism of this uncommon condition had an
importance far beyond the few patients who have it; it led
to the elucidation of the mechanism and of the treatment of
the much more common semicircular posterior canal
BPPV. Treatment of lateral semicircular canal BPPV is less
reliable than of semicircular posterior canal BPPV and
largely consists of rotating the recumbent patient 360
degrees from the bad side towards the good side and then
having the patient sleep only on the good side so that the
otoconia can find their way out of the lateral semicircular
canal back into the vestibule.15

RECURRENT SPONTANEOUS VERTIGO: IS IT MENIÈRE’S DISEASE
OR IS IT MIGRAINE? The patient with repeated attacks of spontaneous vertigo
each lasting an hour or more, most likely has either
Menière’s disease or migraine. The presumed pathophysi-
ological basis of Menière’s disease is episodic endolym-
phatic hypertension which produces devastating attacks of
spontaneous vertigo with nausea and vomiting, together
with a low frequency hearing loss, a low frequency tinnitus,
and a sense of fullness or blockage in the affected ear.16,17
The vertigo attacks usually last for a few hours, but the tin-
nitus and hearing loss might continue for days. The attacks
might occur days, months, or even years apart. After the
first few attacks of vertigo vestibular and cochlear function
recover, so that the caloric test and the pure tone audiogram will both be normal. Later, after many more
attacks of vertigo a permanent loss of auditory and of ves-
tibular function becomes apparent even in between attacks.
Whereas Menière’s disease can remit permanently at any
stage, if it does progress then in the late stages the patient
is still subject to attacks of spontaneous vertigo but also has
the added misery of continual tinnitus in a deaf ear that
distorts and recruits. Strict dietary sodium restriction aim-
ing for a urinary sodium less than 50 mmol/day is the most
effective medical therapy (there has been no proper clinical
trial), more effective and less troublesome than diuretics.
Surgery can stop the vertigo attacks but can’t restore the
hearing. Endolymphatic sac surgery of various sorts is gen-
erally popular, sometimes effective, and should not destroy
any auditory or vestibular function. A surgical, or more
simply, a trans tympanic gentamicin labyrinthectomy will
stop the vertigo but won’t save the hearing, whereas an
intracranial vestibular nerve section will also stop the
vertigo attacks and save whatever hearing remains.
A common clinical problem is the patient who presents
with repeated attacks of spontaneous vertigo, but is
unaware of any temporary deafness, tinnitus, or fullness in
one ear at the time of a vertigo attack, and who has no
clinical abnormalities, a normal audiogram, and a normal
caloric test. (Note: it is not easy to evaluate a dizzy patient
without access to reliable, reproducible caloric testing.)
Could this patient have Menière's disease? The answer is,
of course, yes. The patient might in fact have had a tempo-
rary low frequency hearing loss during the vertigo attack
but would not have noticed it. Patients often don’t notice a
slight hearing loss in one ear, particularly if the loss is
mainly below 1.5 kHz, the centre of the speech spectrum,
and particularly during an attack of vertigo and vomiting
when they are too busy being dizzy to worry about a little
defauness in one ear. There are also patients who have
repeated spontaneous vertigo attacks for many years before
they develop a unilateral tinnitus and hearing loss so that
the diagnosis of Menière's disease finally becomes obvious.
But on the other hand such a patient could also have ves-
tibular migraine.
Those who have migraine headaches have more vertigo
than those who don’t.18 Some migraineurs will sometimes
have vertigo as their migraineous aura, and will then go on
to develop a typical hemicranial headache with nausea and
vomiting. Attacks such as these have been called basilar
migraine, although Bickerstaff19 probably meant something
much more dramatic when he coined the phrase. Other
migraineurs will have repeated attacks of vertigo, apart
from the attacks of headache, typically lasting less than an
hour, with nausea and even vomiting, but without any hearing disturbance or headache at the time.20
The potential mechanism by which migraine might produce vertigo attacks is as open and as contentious as the
mechanism of migraine itself. Nevertheless, vertigo attacks in
migraineurs often respond to medications used to treat
migraine headaches such as an ergot, a triptan, or even
aspirin and in some patients the vertigo attacks can be pre-
vented by regular treatment with a β-blocker, a calcium
channel blocker, a tricyclic, valproate, acetazolamide, or
methysergide.21 As transient neurological events of obscure
origin, in the absence of aura due to migraine, are common
enough in young people,22 it is likely that the same
mechanism, whether that is migraineur or not, can also
cause vertigo attacks in patients who have never had
migraine headaches.

DIAGNOSES THAT ARE UNLIKELY TO BE CORRECT IN A PATIENT
PRESENTING WITH VERTIGO Certain diagnoses should be made with caution in any
patient who has repeated vertigo attacks, and with great
caution in a patient who has only had vertigo attacks and has no fixed loss of auditory or vestibular function and no neurological symptoms or signs. Acute otitis media does not cause vertigo unless there is a suppurative labyrinthitis. Chronic otitis media can, very rarely, produce a Ménière-like picture due to secondary endolymphatic hydrops. A post-traumatic, postoperative, or cholesteatoma associated perilymph fistula can occasionally produce some vertigo, always with a hearing loss. Acoustic neuroma very rarely produces attacks of spontaneous vertigo, and maybe never in a patient who has no fixed unilateral or asymmetric abnormalities of auditory or vestibular function. Microvascular loop compression is a validated cause of paroxysmal symptoms related to the trigeminal and facial nerves, but the evidence that microvascular compression of the vestibular nerve causes paroxysmal vestibular symptoms, or any symptoms at all, is unconvincing. The anterior inferior cerebellar artery normally loops into the internal auditory canal and is not a bona fide cause of symptoms. Whereas frequent brief attacks of vertigo accompanied by unilateral hyperacusis or tinnitus can respond to treatment with carbamazepine and have been called “vestibular paroxysmia” there is scant evidence for symptomatic microvascular compression in these patients. Transient vertebrobasilar ischaemia is a difficult clinical diagnosis at any time but very unlikely to be correct in a patient who has only attacks consisting only of vertigo.

(B) The patient who is having a first ever attack of acute spontaneous vertigo
This is the patient who quite suddenly develops, for the first time ever, such intense spontaneous vertigo, nausea, and vomiting that she or he cannot get to see a doctor, and requires either a home visit (where such things still happen) or a visit to an emergency department. Most general practitioners and emergency physicians will guess, usually correctly, that the patient has “labyrinthitis”, although some will call it a “middle ear infection” and prescribe an antibiotic as well as prochlorperazine by mouth. (How a vomiting patient is meant to take this is rarely explained.) Will call it a “middle ear infection” and prescribe an antibiotic as well as prochlorperazine by mouth. (How a vomiting patient is meant to take this is rarely explained. Nevertheless it can be inferred by testing the subjective visual horizontal, an easy test that can be done in any clinical neurophysiology department. In some patients the disorder only affects the superior vestibular nerve and spares the inferior division of the vestibular nerve so that the patient with vestibular neuritis is able to develop BPPV presumably as a consequence of otoconia being shed from the utricle into the duct of the posterior semicircular canal.

CEREBELLAR INFARCTION
The main differential diagnosis of acute vestibular neuritis is cerebellar infarction. There are several ways to tell the difference clinically. Firstly, there is the head impulse test. In the clinical context of the first ever attacks of acute spontaneous vertigo, if the head impulse test is positive then the patient has acute vestibular neuritis and if the head impulse test is negative, then the patient definitely does not have acute vestibular neuritis affecting the superior vestibular nerve and might have a cerebellar infarct. Secondly, with a cerebellar infarct the nystagmus might be bilateral, might be vertical, and will not be well suppressed by visual fixation—that is, it will be obvious even without Frenzel glasses. Thirdly, a patient with a cerebellar infarct usually cannot stand without support even with the eyes open, whereas the patient with acute vestibular neuritis usually can. If it is not possible to be sure clinically that the patient has acute vestibular neuritis, it is usually because the examining clinician is insufficiently familiar with the technique of the head impulse test to show that it is convincingly positive. In that case imaging will be required, and as many acute cerebellar infarcts are missed by CT, this means MRI. None the less, cerebellar infarction is worth diagnosing, because about a third of cases will develop anterior, potentially lethal, posterior fossa brainstem infarction due to cardioembolic embolism and will require long term oral anticoagulation to prevent recurrences. Although brainstem infarction and brainstem multiple sclerosis might produce an attack with predominantly vertigo and nystagmus, particularly if the plaque involves the 8th nerve root entry zone there will generally be other, albeit subtle signs to indicate that the process is in the brainstem and not in the labyrinth.

LATE COMPLICATIONS
The patient who has an attack of acute spontaneous vertigo and is seen at home by his general practitioner and treated as having labyrinthitis will only see a neurologist if complications occur. So if the patient has actually had vestibular neuritis, there is a 1 in 5 chance that he will present later with attacks of typical posterior semicircular canal BPPV or with imbalance due to inadequate vestibular function. If the patient has had a small embolic infarct in the cerebellum, he might not present until he has had another one, this time perhaps not in the cerebellum but elsewhere.
(C) The patient who is off balance
There are many reasons for a patient to be off balance while standing or walking, a symptom which many patients will insist on calling “dizziness”. Whereas it is true that the older the patient the less likely that a single diagnosis can be made to account for the problem, there are some diagnoses that tend to be forgotten.

The first is bilateral loss of vestibular function which causes ataxia and oscillopsia but not vertigo.31 In the absence of any significant and relevant hearing loss it can cause some diagnostic difficulties because an aural cause might not be considered in the differential diagnosis of imbalance. The patient will be able to walk perfectly well heel to toe and the only easily demonstrable abnormality will be an inability to stand, with the eyes closed, but only when trying to do so on a soft, yielding surface such as a mattress or two pillows—a sort of Romberg’s test. The head impulse test will be positive to the left, right, up, and down and caloric and rotational tests will show bilaterally absent or severely impaired lateral semicircular canal vestibulo-ocular reflexes. Sometimes patients with severe unilateral loss of vestibular function will present with the same symptoms.32 The most common known cause of bilateral vestibular loss without hearing loss is gentamicin toxicity.33 Systemic gentamicin is rarely cochleotoxic in humans, but as far as the vestibular system is concerned there is no safe dose, and any patient who notices imbalance after a hospital admission has gentamicin vestibulotoxicity until proved otherwise. As the patient might not be aware of having been given gentamicin it might be necessary to requisition the hospital’s records.

A few patients have bilateral vestibular loss and normal hearing on a hereditary basis,34 sometimes in combination with a spinocerebellar ataxia.35 Although it will be difficult to recognise a bilateral vestibulopathy in a patient with a cerebellar ataxia from examining stance and gait, the compensatory eye movements in response to slow head turning are pathognomonic. As smooth pursuit is absent due to the cerebellar ataxia and the vestibulo-ocular reflex is absent due to the peripheral vestibulopathy, even in response to slow head rotations the patient will be unable to make smooth compensatory eye movements to maintain fixation and can only produce a series of saccades.

Patients with normal pressure hydrocephalus often have imbalance as the cardinal feature of their presentation and it is easy enough to discount ventriculomegaly in the presence of some cortical atrophy. Nevertheless, there are patients with big ventricles whose gait improves after ventricular shunting.36

Posterior fossa tumours, particularly those within the fourth ventricle, are still a trap particularly if the patient has only had CT imaging. The sole complaint might be of a vague imbalance and perhaps some positional vertigo with no clinical abnormalities.37 This type of presentation deserves MRI. Early progressive supranuclear palsy can present with imbalance and a tendency to fall, well before any eye signs have developed.38 The only clue might be some axial rigidity and a somewhat impassive countenance. Primary orthostatic tremor typically causes no problem with walking but a feeling of imbalance while standing. The patient might not have noticed the fine high frequency tremor, which might only be obvious with surface EMG.39

(D) Conclusions and take home message
With some knowledge, some resources, and considerable patience it is now possible to make a reasonable diagnosis and to offer reasonable treatment to most patients presenting with vertigo or some other balance disorder.

IN THE PATIENT WITH REPEATED ATTACKS OF VERTIGO
(1) Always do a positional test.
(2) Learn to do the particle repositioning manoeuvre.
(3) Always order an audiogram.

Figure 2 The head impulse test. The examiner turns the patient’s head as rapidly as possible about 15 degrees to one side and observes the ability of the patient to keep fixating on a distant target. The patient illustrated has a right peripheral vestibular lesion with a severe loss of right lateral semicircular canal function. While the examiner turns the patient’s head to toward the normal left side (top row) the patient is able to keep fixating on target. By contrast, when the examiner turns the patient’s head to the right vestibulo-ocular reflex fails and the patient cannot keep fixating on target (E) so that she needs to make a voluntary rapid eye movement—that is, a saccade, back to target (F) after the head impulse has finished; this can be easily observed by the examiner. It is essential that the head is turned as rapidly as possible otherwise smooth pursuit eye movements will compensate for the head turn. (Based on a figure from Halmagyi and Curthoys.26)
In the patient who is off balance

**Spontaneous vertigo**

1. Beware of the posterior fossa tumour.
2. Always think of cerebellar infarction.
4. Forget about vertebrobasilar insufficiency as a cause of isolated vertigo.

**Who should treat psychiatric disorders in neurology patients?**

Few neurologists doubt that a significant proportion of the patients who consult them have a psychiatric disorder of at least moderate severity. It is well established that conditions such as epilepsy, Parkinson’s disease, multiple sclerosis, and cerebrovascular disease are associated with an increased vulnerability to anxiety disorders, affective disorders, and psychoses. The predisposition probably results both from the functional disability associated with the neurological condition and also from disturbance of intracerebral neurotransmitter pathways. In addition to those with established organic disease neurologists are consulted by a considerable number of somatising patients, those with little or no organic pathology but who have various neurological symptoms masking an underlying psychiatric disorder.

The paper by Carson et al* on pages 202–206 of this volume indicates the extent of this phenomenon in general neurological outpatient practice and confirms previous studies in this area. Only a minority of all patients with an emotional disorder were considered by their general practitioner or neurologist to require some form of psychological or psychiatric treatment. The exception was the group with unexplained symptoms, in over half of whom the neurologist thought that such treatment was required.
In a previous survey of neurological inpatients the prevalence of psychiatric morbidity, estimated by a standardised two-stage assessment, was 39%, of which 72% was not recognised by the neurologists. Patients were divided on whether they wished to discuss their mood with the clinician. Fifty-five percent thought that such an inquiry would have been unhelpful. Reasons given included the lack of privacy of hospital wards and the inability to see the consultant without the presence of an accompanying entourage of junior doctors and other professional staff. However, few patients with an emotional disorder expressed a need for psychiatric or psychological treatment, raising the question of what is the most appropriate management for their problems.

Neurologists, in keeping with other clinicians, must by now be bored by critical comments from psychiatrists that they fail to recognise psychiatric disorders in their patients. The study of Carson et al indicates that even when the disorders are recognised, patients are reluctant to embark on any form of psychological treatment. They resist psychiatric referral for various reasons, including the perceived stigma of psychiatric illness and also because of their conviction that their symptoms are due to a physical rather than a psychological process. It is likely that for most patients, such as those identified in this study, management of their psychiatric problems will have to be undertaken jointly by the neurologist and general practitioner. This particularly applies to those patients whose emotional disorders coexist with an underlying neurological disorder. The fledgling specialty of liaison psychiatry does not have the resources to deal with the numbers of patients, such as those identified in this study, management for their problems.

Patients who somatise are much more likely to accept psychiatric treatment if an attempt is made to modify the way they perceive their symptoms. The simple techniques of cognitive behaviour therapy can help the patient reattribute the symptoms and recognise them as being linked with an underlying emotional problem which requires appropriate intervention. It has been demonstrated that the techniques of reattribution can be taught to general practitioners1 and when applied in practice they can reduce the levels of psychopathology. The acquisition of cognitive behaviour therapy skills will facilitate the management of such patients in the general practice surgery and neurology clinic.

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REVIEW SERIES

Neurological aspects of tropical disease

The set of six review articles Neurological aspects of tropical disease published in this and subsequent issues of the Journal is an attempt to highlight some of the important neurological diseases in the tropics. We make no apologies for choosing six infectious diseases, as we think that such diseases still represent the major burden of disease in the developing world. We cannot hope to provide a comprehensive review of the subject and the selection of what to include may not be everyone’s choice. All the authors are currently (or were until very recently) involved in clinical practice or in research in the conditions that they review. In the United Kingdom, tropical medicine has traditionally been the preserve of specialists, usually allied to departments of infectious diseases. There are strong historical and contemporary reasons for this and on balance the discipline has been well served by the arrangement. However, the subspecialties in internal medicine in the developed world have progressed so much over the past few years that it is almost impossible for the true generalist (the tropical medicine specialist) to maintain an up to date grasp of each specialty. Such knowledge is critical in tropical medicine. Although a patient may present with malaria or tetanus the management challenges are often those of the paediatrician, the renal physician, the cardiologist, or the neurologist. The development of subspecialties in paediatrics has lagged behind those in adult medicine. For example there are only a handful of paediatricians who have been trained in paediatric neurology and developmental medicine working in sub-Saharan Africa, besides South Africa. The impact of infectious diseases and nutritional deficiencies has only become evident recently.

We hope that this series will achieve three things. The first is to provide a contemporary review of neurological infectious diseases important in the tropics. The increased mobility of people and globalisation of disease means that neurologists world wide may be asked to see such patients in their own practice. We hope that the reviews will be helpful in guiding management in that setting. Access to medical information is still difficult in much of the tropical world. Our second hope is that the Journal will make this series available to areas of the world where it is not usually read.
Our third hope is that these articles may stimulate neurologists, paediatricians, and psychiatrists (and those in training in these specialties) in the United Kingdom and beyond to become more actively involved in clinical practice and research in neurological diseases in the tropical world. There is no doubt that infectious diseases will continue to be a major cause of morbidity and mortality in the tropics and hence the emphasis in this series on such diseases. However, the Global Burden of Disease Study has predicted that patterns of disease will change dramatically by the year 2020 with an increase in the incidence of non-communicable diseases. There is very little reliable information on the burden of psychiatric conditions, epilepsy, cerebrovascular disease, or other diseases affecting the nervous system in the tropical world. As the specialty of tropical medicine evolves to become a specialty of medicine in the tropics the interaction with other disciplines such as neurology, developmental medicine, psychiatry, and rehabilitation should become increasingly important.

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