Evidence for an association between the CSF HVA:5-HIAA ratio and aggressiveness in frontotemporal dementia but not in Alzheimer’s disease

In their recent paper, Soderstrom et al. confirmed their preliminary data suggesting that the CSF HVA:5-HIAA ratio was associated with psychopathic traits and, in particular, violent and aggressive behaviour with childhood onset and adult expression. These findings might indeed reflect changed dopaminergic activity, possibly as a result of serotonergic dysregulation. We hypothesise that their findings might be applicable to other brain disorders characterised by specific behavioural disturbances, including aggression and agitation. Indeed, since several studies have found associations between altered serotonergic neurotransmission and aggression in persons with dementia,3,4 we could propose that the CSF HVA:5-HIAA ratio might be associated with aggression in persons with dementia as well. To test this hypothesis, we performed an interim analysis on 102 out of 302 patients who were included in a prospective and longitudinal study on neurochemical and genetic correlates of behavioural and psychological signs and symptoms of dementia (BPSD). The data presented further support a general application of the interesting findings of Soderstrom et al.1

Patients with various neurodegenerative forms of dementia were included in this prospective study, and were followed up by means of a neuropsychological and behavioural assessment every six months. In any case of death, brain autopsy was performed for neurochemical analysis as well as for neuropathological confirmation of the clinical diagnosis. All subjects and their caregivers gave informed consent to participation in the study, which was approved by the local ethics committee.

At baseline, behaviour was assessed by means of a battery of behavioural assessment scales which included the Behavioural Pathology in Alzheimer’s Disease Rating Scale (Behave-AD) and the Cohen-Mansfield Agitation Inventory (CMAI). Lumbar puncture was performed between 9 and 10 am on April 8, 2002, in the study, which was approved by the local ethics committee.

Extensive radiculopathy: another false localising sign in intracranial hypertension

We read with interest the review by Lamer on false localising signs. Among the various false localising signs described in patients with intracranial hypertension (ICH), radiculopathy is an important manifestation which is probably under-recognised. Many authors have documented subtle features of radiculopathy in patients with isolated intracranial hypertension (IIH). The usual manifestations of radiculopathy in these cases were acral paraesthesias,2 and backache and radicular pain.4 Rarely, motor deficits due to radiculopathy caused by ICHT have been described.5

Obied et al. reported two patients with extensive radiculopathy due to ICHT: one individual had IIH and the other had cerebral sinus venous thrombosis. Both persons had papilloedema, marked visual impairment, and flaccid areflexic quadriparesis with normal MRI of brain, brainstem, and cervical spinal cord. The electrophysiological findings were consistent with radiculopathy. Both individuals initially received intravenous immunoglobulin for Guillain–Barre syndrome, without benefit, but they responded well to lumbo-peritoneal shunting. We also encountered two such cases with angiographically proven cerebral venous sinus thrombosis.6

The most likely mechanism at the basis of radiculopathy appears to be similar to that of other cranial neuropathies in ICHT—that is, mechanical compression of nerve roots, due to elevated CSF pressure distending the subarachnoid space. Documented enlargement of spinal subarachnoid space and distended root pouches in a patient with radicular pain and areflexia due to IIH supports this view.7 Radiculopathy secondary to ICHT has been reported almost exclusively in patients with IIH or cerebral venous sinus thrombosis. Other causes of ICHT may not induce a diffuse increase in pressure in both intracranial and intraspinal compartments, and are unlikely to manifest as radiculopathy. The constellation of flaccid-areflexic quadriplegia and papilloedema may be misdiagnosed as Guillain–Barre syndrome with papillodema.8 Careful analysis of the evolution of symptoms, estimation of CSF pressure, and appropriate vascular imaging should help to correctly identify the cause of ICHT.

References

5. References

www.jnnp.com
Role of entacapone in later Parkinson's disease not yet established

The study by Brooks and Sagar, along with a number of previous others, demonstrates benefit for the catechol-O-methyltransferase (COMT) inhibitor entacapone when compared with placebo in Parkinson's disease (PD). However, this is insufficient evidence to justify the authors' conclusion that "it appears logical to employ levodopa combined with entacapone routinely". The important issue is not whether entacapone is more efficacious than placebo, but whether it is more or less clinically effective and cost effective than the other available treatments for patients with PD that is no longer adequately controlled by levodopa alone. Other available agents—including dopamine agonists and monoamine oxidase type B (MAO-B) inhibitors—have also shown efficacy when compared with placebo. The paper would have benefited from a balanced discussion of the merits of entacapone compared with these other available treatment options.

Such a discussion is likely to be inconclusive, however, as there is a dearth of reliable evidence on the best treatment for PD, at any stage of the disease, since very few trials directly comparing active treatments have been undertaken. Companies are reluctant to undertake such trials, as it is not in their commercial interests to risk studies that might show their product to be inferior to their commercial interests to risk studies that are not in their long term impact on patient-rated measures of overall quality of life, are still needed to define their role in routine clinical practice.

K Wheatley, N Ives, R Gray
University of Birmingham Clinical Trials Unit, University of Birmingham, Birmingham, UK

C Clarke
City Hospital, Birmingham, UK

Competing interests: We are investigators in the PD MED trial and thus have a vested interest in obtaining objective evidence on the best treatment for PD. CC has received honoraria and consultancy fees and travel expenses from the manufacturers of many of the drugs discussed.

References
4 Lexchin J, Bero LA, Djulbegovic B, et al. Pharmaceutical industry sponsorship and research outcome and interpretation of the results of independent studies are also likely to be more objective than those of commercial studies. The potential for bias in commercial trials has recently been highlighted by systematic reviews and journal editors—for example “systematic bias favours products which are made by the company funding the research” and “scientific studies can be manipulated in many ways to give results favourable to companies”.

There are problems with the trial reported by Brooks and Sagar, and these are common to many PD trials, which are generally of poor methodological quality. In a progressive condition such as PD, it is important to evaluate the long term effects of treatment, and six months follow up is inadequate. The outcome measures used should reflect the impact of treatment on the patients' own perception of their functioning and quality of life, not that of clinicians as with the Unified Parkinson's Disease Rating Scale (UPDRS). It is unclear how well the data obtained from off-diary diaries correlates with global quality of life, and whether to treat (ITT) analysis was performed, since patients who withdrew from treatment were excluded from the analysis—ITT analysis requires such patients to be followed up and included in the analysis according to the arm to which they were allocated even if they have withdrawn from allocated therapy. Nearly 50% more patients (24.1% v. 16.5%) dropped out of the entacapone arm than from the placebo arm and, in progressive diseases such as PD, dropout bias tends to favour the active treatment. Thus, although COMT inhibitors are welcomed additions to the treatment options in PD, large, rigorously conducted comparative trials, assessing the long term impact on patient-rated measures of overall quality of life, are still needed to define their role in routine clinical practice.

First, it is not entirely clear whether their fig 2 (left panel) shows portal-systemic or arterovenous shunts. The authors say that the figure shows a selective angiogram of the super mesenteric artery. If that were the case, there should not be a “feeding artery” involved in the intrahepatic shunts (as they state in the legend to fig 2). Instead, the figure would show the portal phase of the angiogram and show a feeding artery (the hepatic artery) and arterovenous (not portal-systemic) shunts. Interestingly, there is evidence to suggest that both types of shunt have been identified as potential routes of neurological complications in the presence of an intact (or mostly preserved) hepatic parenchyma. Thus excessive quantities of potentially toxic substances (for example, manganese) passing directly from the gut to the systemic circulation through portal-systemic shunts could be rapidly cleared by a normal liver as long as the hepatic arterial blood flow is adequate.

Second, Yoshikawa and colleagues claim that the parkinsonism of their patient was induced by manganese. While this is a reasonable working hypothesis, the authors provide no direct evidence supporting such a statement. The fact that they were manganese raised does not necessarily imply that manganese played a key role in the pathogenesis of parkinsonism. Indeed, their patient lacked clinical features often seen in cases of manganese induced parkinsonism (for example, cock walk and propensity to fall backwards).

Levodopa unresponsive parkinsonism is a well known manifestation of chronic non-Wilsonian hepatocerebral degeneration. Although blood concentrations of ammonia were within the normal range in the case reported by Yoshikawa and colleagues, the possibility of ammonia producing directly from ammonia occurring particularly after meals was not investigated.

R de la Fuente-Fernández
Division of Neurology, Hospital A Marcide, Estrada San Pedro-Caballés s/n, 15405 Ferrol, A Coruña, Spain

Correspondence to: Dr Raúl de la Fuente-Fernández, rfuente@medynet.com

References

Authors' reply
We are pleased to have an opportunity to comment on the important issues raised by Dr de la Fuente-Fernández regarding a case of hereditary haemorrhagic telangiectasia
with parkinsonism. Raised serum manganese combined with the abnormal findings in cranial magnetic resonance imaging and abdominal angiography were the rationale for our conclusion that the parkinsonism in our patient was induced by manganese had accumulated because of portal-systemic shunting.

After the angiogram: the angiogram of the superior mesenteric artery presented in our manuscript showed a dilated feeding artery, a dense mottled hepatogram, and early filling of the hepatic vein. These findings concerned the arterial phase. The intrasplanchnic arteriovenous shunts were definite diagnostic evidence of hereditary haemorrhagic telangiectasia but not of portal-systemic shunts. We therefore agree with Dr de la Fuente-Fernández that we should have presented another angiogram in the portal phase showing a hypoplastic portal vein with abnormal vessels between the mesenteric and inferior vena cava to confirm the portal-systemic shunt.

About the parkinsonism: after the failure of treatment by levodopa, we took other measures to relieve the parkinsonism; for example, we persuaded the patient to avoid manganese-rich foods such as blueberries. Fortunately, her serum manganese gradually decreased below the normal upper limit during the next six months, and her neurological symptoms became less prominent. Alleviation of parkinsonism in inverse proportion to serum manganese concentrations suggests that the parkinsonism in this case may have been caused by manganese accumulation, and that the patient was in the early stage of manganese intoxication in which neurological symptoms were incomplete and partially reversible.

About transient hyperammonaemia: we searched for cases of hyperammonaemia related parkinsonism, and finally found a case with portal-systemic encephalopathy and parkinsonism which disappeared after treatment of the portal-systemic shunting. The mechanism of parkinsonism in that case is slightly open to debate, as hyperammonaemia is generally thought to cause disturbance of consciousness or negative myoclonus rather than parkinsonism. We do not deny the possibility that our patient may have had a transient increase in serum ammonia, though it seems unlikely when there had never been a disturbance of consciousness.

K Yoshikawa, M Nakagawa
Department of Neurology, Research Institute for Neurological Diseases and Geriatrics, Kyoto Prefectural University of Medicine, 465 Kawaramachi-Hirokoji, Kamigyo-ku, Kyoto 602-8566, Japan

Correspondence to: Dr K Yoshikawa, kyoshih4@kpuv.kpu-m.ac.jp

Reference

Intraventricular assessment of preoperative electrographic recordings
The paper by Song et al describes the placement of intraventricular arrays with endoscopic assistance for preoperative electrographic recordings for epilepsy surgery. The 4.2 mm outer diameter rigid endoscope was introduced up to the temporal ostium from where the arrays were advanced until a point of resistance was felt.

In our paper, we reported the use of a 1.2 mm outer diameter semirigid endoscope to explore the contents of the ventricles prior to electrode placement, with direct visualisation and electrographic recordings for the final electrode position, which helped us obtain appropriate pre-resection electrographic recordings. Perhaps it would be more convenient to use semirigid endoscopes or flexible fibrescopes to fully visualise the ventricle as well as flexible arrays to avoid electrode displacement resulting in unintentional cerebral lesions.

O H Jiménez
Dept Neurosurgery, Hospital General “Dr. Miguel Silvia”, Secretaría de, Salud de Michoacán, México

N Nagore
Dept Neuropsychiatry, Universidad Michoacana de San Nicolás de Hidalgo, Morelia, Michoacán, CP 58000, Mexico

Correspondence to: Dr O Jiménez, ohjy@yahoo.com.mx

References


Parkinsonism and persistent vegetative state after head injury
Matsuda et al recently reported three patients with a persistent vegetative state (PVS) after severe head injury who, after recovering from prolonged disturbance of consciousness, presented parkinsonian features (mainly rigidity and hypokinesia) which improved after levodopa treatment. MRI studies showed lesions in the dorso-lateral midbrain and cerebral peduncles suggesting axonal injury involving the dopaminergic system (substantia nigra and ventral tegmental area). Similar observations were made in a series of 125 patients with severe vegetative state following head injury (survival time 1–10 years). Nineteen of 49 patients surviving in fully developed or mild recovery stages of PVS initially presented with severe to moderate, mainly symmetrical, parkinsonian symptoms (amimia, rigidity, hypokinesia, convergence disorders). Following levodopa treatment, 11 patients showed incomplete and four full improvement of both the PVS and parkinsonism, while four patients showed complete recovery from both syndromes. However, in 15 patients—despite good recovery from the initial PVS and other neurological symptoms (spasticity, frontal and cerebellar symptoms), and long term levodopa treatment—a progressive parkinsonian syndrome (rigidity, hypokinesia) developed in six patients this was associated with unilateral or bilateral resting tremor. In MRI studies done in 34 patients, 32 showed unilateral or bilateral lesions in the midbrain involving both the dorsolateral tegmentum and the cerebral peduncle.

Neuropathological studies were undertaken in 32 patients surviving without essential improvement of the PVS for at least two months after head injury. Parkinsonian syndromes were severe in seven, moderate in five, and mild in four. In addition to older haemorrhages or necroses in the putamen (n = 6), globus pallidus and thalami (n = 8), all brains revealed multiple lesions in the rostral brain stem with unilateral or bilateral focal lesions in the substantia nigra, vascular lesions in the lateral and ventrolateral midbrain in seven, and symmetrical post-axonal cellular depletion and gliosis or unilateral necroses in the substantia nigra in one case each. In nine cases, there was a good correlation between the severity of clinical parkinsonian signs and the severity and extent of nigral lesions; three patients showed severe parkinsonian signs associated with only mild nigral damage, but there was severe bilateral damage to the globus pallidus in two. In four patients the expression of clinical parkinsonian signs was more severe than the anatomical lesions, in particular the damage to the substantia nigra. The distribution pattern of the brain stem lesions correlated with the sequelae of transcerebral shifting caused by increased intracranial pressure; direct or “primary” traumatic lesions to the oral brain stem usually cause acute death, as seen in two young men with rupture of the diencephalon and acute haemorrhage into the substantia nigra or midbrain following severe and acute fatal head injuries. However, in rare patients with long-term survival following head injury, symmetrical necrosis of the substantia nigra without a clinical parkinsonian syndrome has been reported.

The clinical phenotype of post-traumatic parkinsonism often resembles that of post-encephalitic parkinsonism, both showing akinesia, rigidity, hypomimia, rare tremor, and ophatomotor and vegetative disorders. Both the lesion pattern and the therapeutic efficacy of long term levodopa treatment suggest a dysfunction of the striato-nigral dopaminergic system which, however, may show progressive deterioration in some patients with long lasting PVS after severe head injury.

K A Jellinger
Institute of Clinical Neurobiology, Kenyongasse 18, A-1070 Vienna, Austria

Correspondence to: Dr Kurt A Jellinger, kurt.jellinger@univie.ac.at

REFERENCES

Authors’ reply
We greatly appreciate the thoughtful comments offered by Dr Jellinger, and his interest in our report of three cases in a persistent vegetative state (PVS) after severe head injury. The PVS and parkinsonian syndromes were severe in seven, moderate in five, and mild in four. In addition to older haemorrhages or necroses in the putamen (n = 6), globus pallidus and thalami (n = 8), all brains revealed multiple lesions in the rostral brain stem with unilateral or bilateral focal lesions in the substantia nigra, vascular lesions in the lateral and ventrolateral midbrain in seven, and symmetrical post-axonal cellular depletion and gliosis or unilateral necroses in the substantia nigra in one case each. In nine cases, there was a good correlation between the severity of clinical parkinsonian signs and the severity and extent of nigral lesions; three patients showed severe parkinsonian signs associated with only mild nigral damage, but there was severe bilateral damage to the globus pallidus in two. In four patients the expression of clinical parkinsonian signs was more severe than the anatomical lesions, in particular the damage to the substantia nigra. The distribution pattern of the brain stem lesions correlated with the sequelae of transcerebral shifting caused by increased intracranial pressure; direct or “primary” traumatic lesions to the oral brain stem usually cause acute death, as seen in two young men with rupture of the diencephalon and acute haemorrhage into the substantia nigra or midbrain following severe and acute fatal head injuries. However, in rare patients with long-term survival following head injury, symmetrical necrosis of the substantia nigra without a clinical parkinsonian syndrome has been reported.

The clinical phenotype of post-traumatic parkinsonism often resembles that of post-encephalitic parkinsonism, both showing akinesia, rigidity, hypomimia, rare tremor, and ophatomotor and vegetative disorders. Both the lesion pattern and the therapeutic efficacy of long term levodopa treatment suggest a dysfunction of the striato-nigral dopaminergic system which, however, may show progressive deterioration in some patients with long lasting PVS after severe head injury.
injury, who recovered from a prolonged disturbance of consciousness after they were given levodopa.

This journal reports that in cases of prolonged post-traumatic coma the brains showed multiple lesions of primary and secondary traumatic origin and that the highest incidence of lesions was found in the rostral brain stem. These were considered to be almost exclusively of secondary origin, resulting from cerebral and peripheral circulatory disorders, post-traumatic oedema, and increased intracranial pressure. Primary (direct) traumatic lesions to the rostral brain stem usually cause acute death. In contrast to this report, the brain stem injuries in our cases suggested by MRI may have been the primary traumatic lesions. All these cases showed high intensity lesions in the dorso-lateral midbrain on T2 weighted MRI. These findings implied that the midbrain was injured by tentorial compression induced by translatory and rotatory acceleration when the cranium was struck in its sagittal axis, or by postero-lateral damage. MRI findings, particularly in the acute stage, are useful for evaluating primary brain damage. " Furthermore, another distinctive feature of our cases was the anatomical distribution of the lesions was not multifocal but was localised in the cerebral peduncle or the dorso-lateral midbrain, implying diffuse axonal injury involving the substantia nigra or the ventral segmental area. The neuroradiological findings, the clinical features of extra-pyramidal dysfunction, and the efficacy of levodopa treatment all strongly suggest that the dopaminergic pathways were selectively damaged and caused defects in the nigro-striatal, mesocortical, or mesolimbic system. As Dr Jellinger indicates, progressive decapsulation in levodopa treatment is a considerable problem. However, not all our patients have required permanent medication; an example is case 1 in our report, whose recovery was sustained even after the levodopa treatment was discontinued. Some patients may need levodopa only as a trigger agent at the start of treatment to interrupt the vicious cycle of exhaustion of neurotransmitter. However, discriminating which cases fall into this category is very difficult and withdrawal of medication involves ethical problems.

In recent neuropathological and neuro-radiological studies on PVS after traumatic brain injury, the most common structural abnormalities were diffuse axonal injury involving the corpus callosum, the dorso-lateral aspect of the rostral brain stem, and the thalamus. Although the clinical features will vary in such cases, a take-home message which we learned from our three cases is that in any group of patients with PVS after severe head injury there may be some whose dopaminergic systems may have been selectively damaged; such individuals may respond to levodopa treatment. It is necessary to accumulate a great deal more clinical experience and data to elucidate the pathogenesis and pathophysiological mechanism of post-traumatic PVS. We respect Dr Jellinger's careful observations and descriptions of his cases of prolonged post-traumatic coma, and look forward to further views from him on this topic.

W Matsuda, Y Komatsu
Department of Neurosurgery, Tsukuba Medical Centre Hospital, 1-3-1 Amakubo, Tsukuba, Ibaraki 305-0005, Japan

Correspondence to: Dr Wakoaka Matsuda, wako@msu.biglobe.ne.jp

References

Each article is summarised in half a page or so under the headings introduction (or background), methods, results, and conclusion. This is followed by a brief editorial comment which is often interesting and pithy. At least some of this signed editorial comment is derived verbatim, or with only minor paraphrasing, from editorial comment in the journal originally published the chosen paper. So whose opinion are you really reading in the yearbook?

Although interestingly informative outside one's subspecialty, one does need to ask whether the concept of a single volume yearbook isn't becoming submerged by the sheer volume of potential eligible papers published each year. And, although this 2003 yearbook arrived on my desk in December 2003, it predominately covers papers published in 2001, with some from early 2002, and an occasional hangover from 2000. So, it isn't that up to date. I guess libraries will buy it, partly out of habit. But for individuals, £74 is a steep price for neurological coffee table reading.

M Donaghy

Reference

Catatonia: a clinician's guide to diagnosis and treatment


This nicely produced book reviews one of the historically most interesting, but clinically still very important, disorders of neuro-psychiatry. Catatonia, described by Kraepelin in the latter half of the 19th century, was hijacked by Kraepelin to be incorporated into his concept of dementia praecox, and almost disappeared from the literature in the first half of the 20th century, being finally eclipsed by the introduction of effective psychotropic drugs thereafter. But, as Fink and Taylor explore here, catatonia as a diagnosis is still a diagnostic challenge, with causes far beyond schizophrenia and a syndrome with effective treatment, notably, but not exclusively electroconvulsive therapy (ECT).

For those interested in the cerebral basis of psychiatry, a condition with the main presenting signs of mutism, immobility, negativism, posturing, stereotypy, and echo-phenomena cannot fail to attract attention, and the many faces of catatonia (title, chapter 3) are an olla podrida of neuro-psychiatry. It is refreshing to find reference to Leonhard’s work and the cycloid psychoses in a text from American authors, who are thoroughly appreciative of the European literature on their subject, and shly critical of DSM-IV. Their overall conclusions are clear: Catatonia is a common and not a rare syndrome, neuroleptic malignant syndrome is malignant catatonia, catatonia is not usually associated with schizophrenia, and it is a syndrome of motor dysregulation with a good prognosis—if identified and treated early. This book is a pleasure to read, but should be on the imperative reading list for all psychiatric trainees to inform them about the history of their discipline, the importance of neuropsychiatry, and how to write clearly.

M R Trimble

www.jnnp.com
New Oxford textbook of psychiatry, vols 1 and 2

The New Oxford textbook is the latest and largest of the Oxford textbook of psychiatry's stable. The book was originally published in 2000 and has recently appeared in paperback. This is the best modern British textbook of psychiatry. It is over 2000 pages long and comes in two stout volumes. The interna- tional editorship is led by Michael Gelder, Emeritus Professor of Psychiatry at Oxford, with Spanish (Jaun Lopez-Ilbor) and American (Nancy Andreassen) co-editors. The book is inevitably based on a myriad of individual contributions although the choice of contribu tor and standard of editing is exemplary. The first volume covers general issues and the scientific basis of psychiatry, including a number of reviews of neurobiology. Interestingly, psychodynamic contributions have a separate section. The remainder of the first volume is taken up with coverage of the clinical syndromes of adult psychiatry, including substantial coverage of dementia. The second volume includes review of special topics with a number of articles on aspects of the psychiatry and medical conditions. This includes a useful chapter on neurological disease by Maria Ron, and on epilepsy by Bruce Fancome. The remaining part of the second volume addresses the psychia try sub specialties as well as having a substan tial section on psychiatric treatments, both pharmacological and non-pharmacological. This text is my personal first choice when I encounter a problem in the clinic that I want to look up — and I am rarely disappointed by what it says. This is a Rolls Royce of a textbook. There is a tendency to think of books as large as this one (particularly at a price of £125 even for the paperback) as suitable only for libraries. This would be a price of £125 even for the paperback) as books as large as this one (particularly at a price of £125 even for the paperback) as

The parallel brain: the cognitive neuroscience of the corpus callosum

Roger Sperry's research on the cognitive abilities of split-brain patients following callosal section is a landmark in the study of brain-behaviour relationships. His studies firmly established the role of the corpus callosum in inter-hemispheric information transfer. What have we learned more recently about the role of the corpus callosum in cognition? In this book Eran Zaidel (originally one of Sperry's students) and neurologist Marco Iacoboni present 22 chapters based on a 1996 NATO Advanced Science Institute that attempt to answer this question. The central focus is on the classic problem of why reaction time to respond to a light flashed in either visual field differs according to whether the ipsilateral or contralateral hand

is used to respond (known as the Poffenberger effect, after the psychologist who described it in 1912). This is thought to reflect callosal information transfer between the hemispheres; the book uses anatomical, physiological, and behavioural perspectives to address the question of what information is transferred and how the transfer might operate. Many chapters are accompanied by commentaries and editorial comment, giving a flavour of the debates and controversies in the field. Perhaps reflecting the long interval between the original conference and this book, more recent studies that use functional neuro-imaging techniques to investigate callosal function are relatively poorly represented. However, there is still much of interest in this otherwise comprehensive volume. The chapters generally have a basic scientific focus, but chapters on multiple sclerosis, dyslexia and alexia, schizophrenia, and attention deficit hyperactivity disorder also contain much that will interest the practicing clinician.

G Rees

Magnetic resonance imaging in stroke

This book does much more than its title would suggest. Although mainly concerned with magnetic resonance imaging (MRI) in stroke, the text actually covers single photon emission computed tomography (SPECT) and positron emission tomography (PET) imaging as well and is a compilation of the best chapters ever written on computed tomogra phy (CT) in stroke. The approach and content reflect the predominance of neurologists among the editors and authors, with only a few radiologists, and is really aimed at neurologists and stroke physicians. The scene is set in the first chapter with a discussion of the limitations of clinical diagnosis of stroke and the specific role that imaging can play in diagnosing the type and cause of stroke. There is a superb chapter on CT in acute stroke, which exemplifies how the role of imaging in any diagnostic process should be evaluated. Separately, there is a chapter on CT evaluation of cerebral blood flow, a useful and practical introduction to MRI, discussion of conventional structural MR techniques such as T2, FLAIR, and gradient echo sequences, and a section on MR angiography. Much of the rest of the book (about half of it) is given over to diffusion and perfusion MRI, including its evaluation in animal models, concepts of identifying the ischaemic penumbra, evaluation of transient ischaemic attacks, selection of patients for new therapies and drug development trials, and finally a chapter on MR spectroscopy and a (very short) chapter on functional MR after stroke.

Although written by MR enthusiasts, the text is tempered with some discussion of the drawbacks of MR, such as poorer patient accessibility (compared with CT) and problems of metallic foreign bodies. It also makes the point that, despite the huge interest in MR diffusion and perfusion MRI imaging, the precise thresholds of defining irreversibly damaged tissue and tissue at risk are yet to be determined. Some aspects of stroke MRI are not dealt with in much detail, for example classification or interpretation of white matter lesions (frequently found in stroke patients), or the identification and interpretation of microhaemorrhages on MR and how they might influence decisions regarding stroke treatment, or on using diffusion imaging to identify lesions in patients with milder stroke (that is, not just the first few hours). There is very little on practical issues (perhaps reflecting the neurology rather than the radiology approach) such as how to assess a stroke patient who is unable to speak prior to MR to make sure that it is safe for the patient to go into the magnet, and how one manages the patient while in the magnet with respect to factors such as oxygenation.

Some of the authors express personal views that not all readers will agree with. For example, in the chapter on assessment of a transient ischaemic attack (TIA), the authors suggest that the definition of a TIA should be changed to one based on the presence or absence of certain imaging features. Although this clearly represents a personal opinion expressed by the author, it is objection to changing a classification that is so fundamental to stroke epidemiology and clinical practice is that only those with access to an MR scanner with diffusion imaging would be able to correctly diagnose a TIA using this new classification. Not only that, but the diagnosis of TIA might be dependent on the ability of the local radiologist or clinician to spot subtle features of recent ischaemia on diffusion imaging.

I found it a little disappointing that a proportion of the perfusion images were presented in black and white when this is one technique which really requires colour display for proper interpretation and appreciation. In summary, this is a useful textbook, particularly for neurologists or stroke physi cians who need to understand more about imaging and its role in patient characterisation, decision making, and assessment of treatments in acute stroke. It’s not just about MR and everybody with an interest in stroke should read the chapter on clinical efficacy of CT in acute cerebral ischemia. At 250 pages it is easily digestible and yet also a useful reference. At £80.00 I think compared with other books on MR and on stroke it represents good value for money.
The bard on the brain—understanding the mind through the art of Shakespeare and the science of brain imaging


One of the great challenges of popular science writing is to convey a coherent and consistent impression of scientific ideas while avoiding confusing, specialist terminology. The most useful tools for this task are metaphor and pictures. The Dana Press, publisher for the Charles Dana Foundation, has as its mandate “the provision of information about the personal and public benefits of brain research”. With The bard on the brain, they have chosen to use the voice of William Shakespeare, the master craftsman of metaphor, to introduce the areas of human cognition that have attracted the most attention in recent functional imaging research. The target audience presumably consists of non-scientists, or of the fusiform gyrus in face perception or inferior parietal lobe in spatial awareness, to name a few more finely differentiated theory of cortical function than Fuster’s general line of argument suggests. Fuster’s main thesis condemns him to a rather abstract style. But there is much fascinating information to be found here—I particularly enjoyed the closing chapters on language and intelligence—and anyone who is used to locating cortical functions on colourful scans will find cause for thought in these pages.

A Zeman

Parkinson’s disease, diagnosis & clinical management


This multi-authored tome on Parkinson’s disease (PD) admirably captures the complexity and diversity of the many clinical challenges and scientific problems that surround this common neurodegenerative disorder. Contributions over 58 chapters embrace an international body of expertise, with a pronounced north American emphasis, and range from discussing the early history of the condition to a welcome section on social issues, with in depth attention paid to the clinical presentation, including psychological features, structural, chemical pathology, theories of aetiology, drug, surgical, and other treatments, and atypical and familial forms of parkinsonism. The text is generously referenced and well-illustrated with black and white figures. There are impressive chapters on the contribution of MPTP to our understanding of PD, genetic and environmental factors, and the drug classes employed in treatment as well as the complications of treatment, including dyskinesia and motor fluctuations. Proper attention is given to the management of psychosis and cognitive decline, with discussion of the relationship of these features in PD to dementia with Lewy bodies and Alzheimer type pathology. Future avenues of treatment, including neuroprotection and gene therapy, are also covered in this near encyclopaedic compendium, which is highly recommended for all those who treat patients with PD in neurology, geriatrics, and old age psychiatry departments, as well as research scientists in the field, and it should be required reading for all neurological trainees.

R Pearce

Principles and practices of emergency neurology—handbook for emergency physicians


This is a handbook based on an earlier larger book, Emergency neurology: principles and practice, in response to enquiries from emergency medicine residents about whether a handbook, based on this main text, would be available. This is the result. Whether it is justified in calling itself a handbook is hard to say. The area covers three of my hands (small). It runs to over 400 pages with approximately 50 authors. It covers neurological examination and neurodiagnostic
Duchenne muscular dystrophy, 3rd edn


Quite simply, this monograph is essential reading for anybody involved with this devastating condition, and indeed for those involved with any form of muscular dystrophy, whether in the clinic or in the laboratory. Duchenne muscular dystrophy (DMD) is the archetypal dystrophy. It is because the clinical course is so stereotyped that it was the first of the dystrophies to be defined clearly, over a century ago. The historical journey from the first clinical descriptions to our present state of knowledge forms the core of this book, with side branches relevant to the identification of other specific forms of dystrophy, particularly the limb girdle dystrophies. The nihilist may suggest that all of this knowledge has as yet failed to find a cure, but for the clinicians intimately involved with these patients we can now do more than ever to provide an improved quality of life. There is of course great hope that “genetic engineering” will lead to a cure, but patients and their families cannot live on hope alone and Professors Emery and Muntoni have elegantly summarised present management options.

The second edition was published in 1986, a matter of months before the identification of the gene involved in the disease process and its protein product dystrophin. Within a few years it became apparent that dystrophin and dystrophin-associated proteins have a fundamental role in various forms of muscular dystrophy, and for a while it looked as if there might be a common mechanism of membrane fragility due to dysfunction of these membrane associated proteins. Then abnormal cytosolic proteins were found in some forms of limb girdle dystrophy and it became clear that there was no simple single disease mechanism. Despite that, altered function of membrane proteins is clearly of fundamental importance in many dystrophies and Muntoni has been at the forefront of recent discoveries relating to altered glycosylation of the membrane protein z-dystroglycan in various forms of congenital and adult onset limb girdle dystrophies.

There is no need to describe the individual chapters in detail. In brief, the monograph covers the history of the disease (Emery being a noted medical historian), clinical features, differential diagnosis, molecular pathology, pathogenesis, genetic counselling, and management. Emery is retired from clinical practice but the clinical setting is kept up to date by his being joined by Muntoni for this timely third edition.

All those involved in the management of DMD will find something of value in this book. Some patients and families may also want to dip into it. Those interested in the history of medicine, the evolution of modern genetic and molecular techniques, will find it a fascinating story.

Let us hope that a fourth edition, detailing the successes of genetic engineering, will not be too far off, but in the meantime there is much that can be done to alleviate the consequences of this truly awful condition.

D Hilton-Jones

Mental and behavioral dysfunction in movement disorders


It was not long ago that the basal ganglia were confidently asserted to have no influence on cognition, and to have only motor functions. This was the province of neurology, and the concept that they might be involved in disorders of behaviour other than that referred to as movement disorders was anathema to generations of neurologists.

As Goetz notes, in the introduction to this nicely produced book, this view ignored over a 100 years’ of clinical observation, and much subsequent work, theoretical, clinical, neurochemical, and neuroanatomical, all of which underline the central role of the basal ganglia structures in regulating behaviour, in its widest sense, and hence the association between movement disorders and cognitive and behavioural dysfunction.

The openers in this text are with neuroanatomy and neurochemistry, rightly so since the impact of the discovery of dopamine and the unveiling of the new neuroanatomy of the limbic forebrain, have fundamentally altered the way we think about the brain and its disease and what should profoundly influence clinical thinking. A chapter on the cerebellum is also included in the opening section.

The book then contains chapters on two main themes, cognition in movement disorders, including the long controversial area of links with dementia, and the neuropsychiatry of movement disorders. The main diseases discussed are the obvious eponymous ones of Parkinson’s, Huntington’s, and Gilles de la Tourette, as well as cortico-basal degeneration. There are some curious omissions, Wilson’s disease, Sydenham’s chorea, and supranuclear palsy, among others. The cognitive problems embrace such topics as speech disorders and apraxias, and include chapters on animal models as well as clinical research.

The section on neuropsychiatric aspects is laid out rather differently and less systematically. A chapter on mood disorders and the pallidum, another on depression and the basal ganglia, another on psychosis and mood disorders in Huntington’s disease, some disease oriented, others anatomically based. Nevertheless, the individual chapters are, for the most part, well written, and included are contributions on REM sleep behaviour disorder, psychogenic movement disorders, and obsessive compulsive disorder. A separate section is devoted to quality of life studies.

The book is a timely reminder of the growth of interest in and the clinical importance of neuropsychiatry, and quite some space in the text is given to treatment and management issues. No longer can the basal ganglia simply be viewed as structures sub-serving motor function, they represent drives and affects which are re-represented cortically and which propel our very being.

M Trime