Dystonia, tremor, and parkinsonism in a 54 year old man with 2-hydroxyglutaric aciduria

Glutaric aciduria is often considered to be a rapidly progressing dementing illness with only occasional extrapyramidal symptoms, usually described as dystonia. We present a case of late onset 2-hydroxyglutaric aciduria and slowly progressive dystonia and parkin-sonism.

Case report
A 54 year old man was referred to the University of Florida movement disorders center for management of “end stage Parkinson’s disease”. He was diagnosed with developmental delay and mild cerebral palsy by his paediatrician, for a failure to meet motor age norms. He had below average grades in school and graduated high school two years behind his age matched peers. At age 26, he noticed a mild intention tremor in his right hand, a mild head tremor, and mild unsteadiness in walking. These assumed to be potentially parkinsonian fea-tures, and later in his 30s he was given the assumed diagnosis of Parkinson’s disease. He was treated with levodopa, dopamine agonists, a monoamine oxidase inhibitor, and anticholinergics, which all failed to help his symptoms. He was gainfully employed by the city in a maintenance department until being fired in his mid-30s for incompetence. At the time of his clinic appointment, his mother noted progression of disability with swallowing, balance difficulties, and aggressive behaviour. There was no history of exposure to neurotoxins, and he did not smoke or drink alcohol. His brother also had a tremor.

On neurological examination he was alert and oriented to person and place. His memory was tested (3/3 registration and 1/3 recall after five minutes). He had a hypophonic dysarthria with pallilalia. Gerstmann features (left/right confusion, finger anoma-ly, acalculia, and agraphia) were all impaired. He had frontal release signs including a root, snout, grasp, and glabellar tap. He had frontal lobe impairment including problems with Luria 2 and 3 step command testing, anti-saccade testing, problems with crossed response inhibition, and motor im persis-tence. Stereognosis and graphesthesia were intact. Cranial nerve examination revealed only saccadic pursuit. He had a tongue tremor. Power, reflexes, and sensory exami-nation were normal. On cerebellar examination he was hypermetric on finger to nose testing, with past pointing and ataxia.

Movement disorder examination revealed prominent parkinsonian features including rigidity, bradykinesia, shuffling gait, and balance problems. His hands were mildly dystonic. He had mild bilateral postural intention tremors. His posture was stooped and he had decreased arm swing and shuffling steps. He retropulsed on a pull test and could not perform tandem gait. In addition, he had a masked face, pallilalia, and severe micrographia. His off medication Unified Parkinson’s Disease motor scale (UPDRS) examination was 55. After taking his usual medications (trihexphenidyl and selegiline) he was re-examined one hour later and his UPDRS score was unchanged (55). He had more dystonia in his hands while on his medications.

His previous diagnostic evaluation included serological tests which had revealed a normal thyroid stimulating hormone concentra-tion, normal liver function tests, normal ammonia concentration, and normal reactive plasma reagent. Head magnetic resonance imaging revealed that he had revealed one year before presentation and the flair images revealed prominent white matter hyperintensities in the frontal and parietal regions, with posterior ex vacuo dilatation of his lateral ventrices (Fig 1), and mild cerebellar atrophy. Urine organic acids were sent and revealed 2-hydroxyglutaric aciduria.

Discussion
This case demonstrates that older patients with parkinsonism may have inborn errors of metabolism. Our patient was unique in that until his mid-20s and later when he lost his job in his mid-30s, he was assumed to have mild cerebral palsy, and only after developing other parkinsonian features was he later misdiagnosed as having Parkinson’s disease. The important clinical feature that was missed in the patient were the developmental delay, the progression of symptoms leading to a mental incapacity to hold his job, and the parkinsonian features that were unresponsive to levodopa and other agents. In addition, his MRI, which was carried with him to the appointment, had changes indicative of glutaric aciduria. A differential diagnosis in this case should have included other non-levodopa responsive disorders that can present with movement disorders, such as proprionic academia, methylmalonic aciduria, glutaric aciduria, and leucodystrophy. Given his relatively benign course, he prob-ably has L-2-hydroxyglutaric aciduria and not D-2-hydroxyglutaric aciduria. Our patient unfortunately died as a result of an accident shortly after his evaluation, making confirma-tion of the L isofrom impossible.

2-Hydroxyglutaric aciduria is a rare inborn error of metabolism that was first recognised in the L isofrom by Duran and colleagues and later defined clinically by Barth et al. There is less known about the molecular biology and underlying biochemical defect than in other amino acidurias. Further cases have been identified and have detailed clinical, biochemical, radiological, and patholo-gical characteristics that have established a spectrum of the disease. Several subtypes have been identified and hydroxyglutaric aciduria has been proposed to have an autosomal recessive inheritance, occurring in both D and L isofroms. Most of the cases reported in the literature are identified in early childhood. The D isofrom usually presents with neonatal or early infantile encephalopathy, seizures, extrapyramidal symptoms, and cardiomyopathy. In con-trast, the L isofrom may present within the 1st years of life with non-specific motor delay, and later cognitive and motor develop-mental delay. Gait ataxia may occur as early as the 2nd year. Additional findings include occasional pyramidal and extrapyramidal features and dystonia, with a pre-destination for the hands. Progressive mental retardation is common in these patients. Most cases are diagnosed in childhood but Clerc et al. in 2000, reported an adult patient with tremor and excessive urinary excretion of L-2-hydroxyglutaric aciduria. Our case also highlights the possibility of this disorder presenting later in life with dystonia, tremor, and parkinsonism.

Imaging and urine samples are very helpful in making this diagnosis. Neuroimaging findings in L-2-hydroxyglutaric aciduria reveal subcortical leuocencephalopathy (as seen in our case), and may also show atrophy of the cerebellum and cerebral white matter. Ultrasonic and MRI have been normal in this case.}

Figure 1 Flair magnetic resonance images revealed prominent white matter hyperintensities in the frontal and parietal regions with posterior ex vacuo dilatation of his lateral ventrices.
be performed with urine organic acids so that this
diagnosis can be quickly made. With the
emergence of new genetic therapies for
biochemical diseases it may be important in
the future to make this diagnosis early in
the course of the disease.

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Transient myasthenia gravis in an
elderly woman
Myasthenia gravis is usually a chronic dis-
order, although remission rates of 25–30%
can be expected with judicious interven-
tions such as thymectomy and immuno-
suppression in appropriate cases. Spontaneous rem-
sission occurs rarely. Oosterhuis, found
a remission rate of only 1% per annum over
17 years among 180 patients with generalised
myasthenia gravis treated with anticholin-
eresin terases alone.1 We describe a case of ocular and
bulbar myasthenia in which there was
complete recovery over a matter of weeks
without immunosuppressive agents.
The patient, a 78 year old woman, devel-
oped acute, painless left sided ptosis in
October 2002, while on holiday abroad.
There was no diplopia. She had developed
hypothyroidism one year before but was
asymptomatic. On examination in January 2003, there
was no definite ptosis or ophthalmoparesis.

The resolution of clinical symptoms
and the electrophysiological findings, it was
decided to continue pyridostigmine alone
and steroid treatment was not initiated. Her
symptoms continued to improve. By April
2003, she was completely asymptomatic. The
pyridostigmine was gradually withdrawn
over one month. She remained asympto-
matic on follow up in September 2003.
Neurological examination was entirely
normal although her AChR-abs remained
positive at 5.00 nmol/l.

COMMENT
To our knowledge, transient myasthenia
gravis has not been described previously in
a patient of this age. It is known to occur in
10–15% of infants born to mothers with
myasthenia as a result of transplacental
transfer of maternal antibodies, and there is
a report of transient myasthenia in autoim-
mune disease resulting from HIV infection.2
In that study, seven HIV infected patients
presented with transient myasthenic symp-
toms. Four of them had positive AChR-abs. In
one, myasthenia gravis and coincident auto-
immune thrombocytopenia both resolved
following anti-retroviral treatment. Our
patient had no history of preceding infection,
although there was a history of thyroid
disease.

The persistence of high levels of AChR-abs
despite clinical resolution is of interest. There
is no direct correlation between antibody titre
and clinical state of individual patients with
myasthenia gravis.3,4 In view of the improving symptoms and
the electrophysiological findings, it was
decided to continue pyridostigmine alone
and steroid treatment was not initiated. Her
symptoms continued to improve. By April
2003, she was completely asymptomatic. The
pyridostigmine was gradually withdrawn
over one month. She remained asympto-
matic on follow up in September 2003.
Neurological examination was entirely
normal although her AChR-abs remained
positive at 5.00 nmol/l.

Doctor, I can hear my eyes’;
report of two cases with different
mechanisms
An unusual but fascinating symptom is the
one described by patients complaining that
they can hear their own eye movements. We
report two cases, with different postulated
mechanisms.

Case reports
Patient 1
A 53 year old woman presented with a
tendency to fall to the left. She did not
experience hearing difficulties or tinnitus.
Clinical examination was unremarkable
other than increased sway on Romberg.
Pure tone audiometry was normal other than
bilaterally mildly elevated thresholds of
30 dBHL at 8 kHz. However left sided ipsi-
and contra-lateral stapedial reflexes were
elevated, and auditory brain-stem evoked
responses, while normal on the right, showed
increased latency of wave V on the left. Serial
MRI scans demonstrated an enlarging left
vestibular schwannoma. Trans-labyrinthine
resection of the tumour was complicated by a
left cerebellar infarct and hydrocephalus, and
subsequently the patient continued to experi-
ence imbalance. Two years post-operatively,
early questioning about tinnitus led to the
patient describing tonal tinnitus in the left
ear on looking to the left, in which up-gaze
increased the pitch, while down-gaze lowered
the pitch. Notably she said “I feel I could play
a tune with my eyes”.

Patient 2
A 32 year old man presented with visual
instability and a tendency to fall forward and
to the left provoked by loud sounds such as

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the telephone ringing in his left ear. His auditory symptoms included being able to hear his heart beats, bone taps, and footsteps. Additionally he complained of a soft low pitched sound in his left ear “rather like moving a hard-pressed finger across a clean, wet china dinner plate” when he moved his eyes. These symptoms could be reduced if the patient tensed his abdominal muscles. Pure tone audiometry showed normal air conduction hearing thresholds bilaterally other than a mild elevation of 35 dBHL at 0.25 kHz on the left. Bone conduction hearing levels were normal, perhaps even supra-normal, with thresholds of –10 dBHL at 0.5 and 1 kHz bilaterally, giving rise to an “air-bone gap” at these frequencies. Clinical examination and three-dimensional video oculography demonstrated left beating torsional nystagmus provoked by the patient humming, and CT scanning of the petrous temporal bones revealed bilateral dehiscence of the superior semicircular canals (fig 1).

Discussion

Patient 1 has gaze-evoked tinnitus, a phenomenon first described in 1982 that was initially thought to be rare, but subsequently reported to be surprisingly common (prevalence 19–36%) in one study of patients post vestibular schwannoma resection.6 It has also been described in patients with cerebello-pontine angle meningioma, meningeval metastases of malignant melanoma, and sudden sensorineural hearing loss. It may develop months post-operatively, and is usually heard in, and caused by moving the eyes towards, the diseased ear. The exact mechanism is not known, but it has been postulated that neural plasticity mechanisms activated by unilateral deafferentation result in cross-talk between neural elements controlling eye movements and the central auditory system. Indeed, functional imaging studies of patients with gaze-evoked tinnitus have shown anomalous activation of the auditory lateral pons and auditory cortex, enhanced by failure of cross-modality inhibitory mechanisms.1

Patient 2 has Tullio phenomenon, a condition in which sound and/or pressure stimulates the vestibular system. These patients often complain of abnormal auditory sensations such as "hearing footsteps vibrating through the body", and finding the noise of chewing loud enough to make understanding of conversations at mealtimes difficult. Supra-normal bone conduction thresholds, or so-called conductive hyperacusis, has been reported in other patients with Tullio phenomenon, and dehiscence of the superior semi-circular canals is thought to be the commonest associated pathology. It is postulated that the dehiscence may act as an alternative lower impedance pathway for sound energy, enabling these patients to hear the movements of their eyeballs within the bony sockets, these sounds being conducted through the skull. It is interesting to note that although our patient had dehiscence of both superior semi-circular canals, he was only symptomatic on the left side. This could be explained by the Tullio phenomenon being multi-factorial in nature, and additional factors such as trauma or bone remodelling need to be present as well as the dehiscence before the clinical features become manifest.1

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Transient compulsive hyperphagia in a patient with a thalamic infarct

Eating disorders are associated with various psychiatric and neurological diseases. Pathological eating behaviour ranges from reduced to excessive appetite, dysregulation of hunger and satiation signals, and odd food preferences. Hyperphagia and anorexia are reported in lesions (mostly tumours) involving the ventromedial hypothalamus.1 Moreover, eating disorders also occur in temporal lobe tumours, temporal lobe epilepsy, and advanced states of degenerative disease with neuronal loss in the medial temporal lobe. Hyperorality is part of the Kluver-Bucy syndrome which occurs in patients with bilateral mesial temporal lesions. We report a patient in whom compulsive hyperphagia was associated with a medial thalamic ischaemic stroke.

CASE REPORT

A 52 year old man complained of diplodia, dizziness, vertigo, decrease of consciousness, memory impairment, and hyperphagia. These symptoms occurred abruptly while he was painting the gate in his garden.

The diplodia and vertigo disappeared in about 15 minutes, while hyperphagia and memory impairment lasted for about 24 hours and completely disappeared the following day on awakening. Instead, amnesia concerning the event is still present.

The decrease of consciousness consisted of slight hyposomnolence (the patient could easily be awakened by auditory and verbal stimulation) and was present only at the onset, while memory impairment was noted only later. The patient’s wife reported that he kept repeating the same questions to her, and at times all the food he found in the refrigerator and in the kitchen. Apart from the fact that he was eating continuously all day long, when it was time for his lunch and evening meal, he always felt hungry and ready to eat, his main concern was food, and his attention could not be diverted during his meals.

The following day his wife took him to the hospital. Neurological examination on admission revealed only retrograde amnesia about the events that had occurred in the previous 24 hours, along with fatuous behaviour. The medical history was not significant. Cranial computed tomography and extracranial Duplex ultrasonography were normal. Six days later, brain magnetic resonance imaging (MRI) revealed an ischaemic lesion involving the medial portion of the left thalamus in the territory of the tuberothalamic perforating artery (fig 1). MRI-angiography of extracranial and intracranial cerebral arteries was normal.

A transthoracic echocardiogram was normal, while a transoesophageal echocardiogram revealed an atrial septal defect without a patent foramen ovale. Conventional vascular risk factors (hypertension, diabetes, hypercholesterolaemia, and smoking) were absent. Routine laboratory studies including coagulation profiles were normal.

During the hospital admission, the patient’s clinical condition progressively improved and he was discharged eight days later without any neurological symptoms.

Two weeks later he was submitted to a neuropsychological test battery to assess reasoning (Raven PM47), short term memory (verbal and spatial span), learning (paired associate and Corsi spatial learning), attention (visual search), and frontal executive functions (Nelson card sorting test, trial making B, category, and literal fluency). Anxiety and depression were investigated by the state-trait anxiety inventory and the Beck depression inventory. Results were within the normal range (<1 SD) for all the tests.

COMMENT

The anatomical substrates of eating disorders are conventionally the basal ganglia and the cortico-limbic areas. In our patient compulsive hyperphagia was associated with the clinical features of medial thalamic ischaemia. The patient presented with signs and symptoms of the so called “top of the basilar
Other endocrine dysregulations and satiation signals are associated with causes by hypothalamic dysfunction are from the posteromedial thalamus (PMT), which contains the rostral interstitial nucleus of the medial longitudinal fasciculus, the posterior inferior portion of the dorsomedial nucleus, the nucleus parafascicularis, the intralaminar nuclei, and sometimes the mamillohthalamic tract. Unilateral infarcts of the PMT may cause a decrease in consciousness and neuropsychological disturbance (patients will be disoriented, unconcerned, apathetic, and may engage in behaviour involving the compulsive use of objects out of the behavioural context). A visual deficit (diplopia and vertical gaze functional impairment with up gaze palsy or combined up and down gaze palsy) are often reported because of the involvement of the upper mesencephalon. Neuropsychological disturbances are more marked and long lasting in patients with bilateral PMT infarction. Except for visual dysfunction, similar features are reported in anteromedial thalamic infarction.

In diencephalic lesions hyperphagia may result from hypothalamic, thalamo-cortical, or limbic dysfunction. Lesions involving the ventromedial hypothalamus, the amygdala, and the fibre bundle from the substantia nigra to the basal ganglia alter the signal of satiation and food intake. Eating disorders caused by hypothalamic dysfunction are characterised by dysregulation of hunger and satiation signals and are associated with other endocrine dysregulations. Cortical lesions may cause eating disorders if they involve the temporal and frontal association areas connected to the basal and diencephalic systems. Moreover, clinical observations and animal studies suggest that the limbic structures and their connections are strongly involved in the regulation of appetite.

In our patient the acute occurrence of compulsive eating was part of a complex behavioural and neuropsychological disturbance typical of medial thalamic dysfunction. Behavioural abnormalities may be more easily explained by bilateral involvement of the medial thalamic region. Indeed an embolic occlusion of the distal portion of the basilar artery may have caused a transient bilateral thalamic ischaemia. The definite infarct involved the left thalamus and was completely asymptomatic.

In our patient we believe that transient thalamo-cortical dysfunction because of impairment of the connection between the medial thalamic nuclei and the frontal or temporal lobes may have been the determinant of the compulsive hyperphagia. This compulsive hyperphagia may be the equivalent of the utilisation behaviour described in bilateral PMT infarction, in which patients automatically and inappropriately handle and use objects placed before them, even though not told to use them.

### Case study: cerebrovascular parkinsonism with levodopa addiction

Levodopa (L-dopa), the mainstay of treatment for idiopathic Parkinson’s disease (IPD), has a mild stimulant effect and may cause agitation, restlessness, and euphoria even in normal subjects. It is associated with a well documented withdrawal syndrome consisting of confusion, muscular pain, and rigidity. This can progress to involve symptoms comparable with neuroleptic malignant syndrome, including pyrexia and increased creatine kinase.

There is now good evidence that L-dopa is addictive, and there are many case reports of patients with IPD who seek to increase their L-dopa dose to high levels because of psychological dependence rather than therapeutic benefit. The largest series of such patients suggested that L-dopa dependence results in paranoia, hypomania, hypersexuality, and euphoria associated with weight loss and severe dyskinesias. Many of the behavioural changes are similar to those seen in amphetamine or cocaine abusers and have been termed “hedonistic homeostatic dysregulation”.

### CASE REPORT

An 81 year old woman had been diagnosed with Parkinson’s disease 10 years before. She reported a five year history of extremely frequent but intermittent severe pain and stiffness in all her muscles, resulting in severe disability and distress. Her general practitioner had tried amitriptyline and baclofen with no effect. The only effective treatment was Madopar, a combination of levodopa and benserazide hydrochloride, which she took in large doses every two hours. She admitted taking in excess of 2.3 g every 24 hours. She even woke in the night to take Madopar tablets. She was obsessive about her drug regimen and would not allow even minor changes. Her husband said that she was hostile, paranoid, and very demanding. She had never suffered from hallucinations or dyskinesias.

Her previous records indicated ongoing problems with weight loss, investigated over several years but with no apparent cause. She had undergone computed tomography of the brain in 2001, which showed multiple white matter lesions secondary to chronic ischaemic damage.

She presented as a cachectic, frail, elderly woman who became very dependent on amphetamine or cocaine abusers. She weighed 34 kg. She was unable to stand up or walk owing to pain and stiffness. She was slightly confused, with a mini-mental state examination (MMSE) score of 24/30. She appeared to be in constant pain and was uncooperative with examination. Despite this, she had no evidence of tremor, rigidity, or bradykinesia. There were no other significant neurological findings.

She was admitted to hospital for slow supervised withdrawal of her Madopar. Blood tests including blood count, electrolytes, creatine kinase, thyroid function, and inflammatory markers were all in the normal range. She refused further investigation by magnetic resonance imaging or single photon emission computed tomography. She was only able to tolerate a very slow withdrawal of L-dopa owing to severe muscular pain, and it took two separate admissions over five months to complete the withdrawal.

It was possible to keep her off L-dopa for a period of four weeks, during which she regained her appetite and weighed 40 kg. She was clear in her mind and her MMSE score was 30/30. She was no longer analagous and no longer wanted to take L-dopa treatment. She became pain-free. Her...
handwriting was large and legible. She was able to walk with a Zimmer-frame, but had a wide based shuffling gait compatible with a diagnosis of small vessel cerebrovascular disease.

Following that period she became depressed and withdrawn. Paroxetine did not help but the reintroduction of Madopar, in a dose of 62.5 mg three times daily, helped to alleviate the depression. After one year of follow up she remained mobile with help. She had not developed tremor, extrapyramidal rigidity, or significant bradykinesia. Her appetite and alertness continued to be good. She refused any further reduction in the dose of L-dopa.

COMMENT
Despite its high prevalence, IPD is often a challenging diagnosis. Up to 25% of patients considered to have this condition by a neurologist may have an alternative diagnosis. In the community, the diagnosis may be wrong in nearly 50% of cases. Where there is difficulty in making a diagnosis, a trial of L-dopa is often useful. However, it is possible that L-dopa dependency can occur even in patients without IPD. They can develop withdrawal symptoms of muscular aching and stiffness, which superficially resemble worsening parkinsonism and obviously respond well to L-dopa, giving the impression of a helpful treatment. In our patient’s case, larger and larger doses of L-dopa were prescribed over many years, leading to physical and psychiatric effects compatible with “hedonistic homeostatic dysregulation.” She became profoundly disabled as a result of L-dopa dependence, the manifestations of which were much worse than the symptoms with which she had initially presented.

The psychiatric effects of L-dopa dependence are well documented, including severe depression after withdrawal. However, the characteristic severe muscle pain suffered by our patient has not been reported before. We speculate that long term L-dopa treatment causes changes in the expression of central dopamine receptors such that withdrawal leads to unpleasant symptoms, even in people without Parkinson’s disease. A similar mechanism may underlie the development of “dopaminergic malignant syndrome”.

It is our suspicion that there may be other patients without IPD who are dependent on L-dopa. It is important that L-dopa is not considered a benign medication, and trials of treatment with this agent should be carefully supervised. Any patient taking L-dopa in large doses without dyskinesias should have the diagnosis reconsidered. Any patient with IPD in whom muscle pain is a prominent symptom, especially associated with weight loss and psychiatric problems, should have their use of L-dopa investigated. It is worth noting that in the case of our patient, the actual doses of L-dopa taken were nearly double those recorded in the medical notes.

Finally, patients with L-dopa addiction, both with and without IPD, represent a great challenge in management. The prognosis is recognised to be poor. In our patient’s case, Madopar was withdrawn only with her informed cooperation and that of her husband, who had given her drug treatment for many years. Other patients simply refuse to comply with drug changes and may even change specialists to secure an L-dopa supply. The successful outcome in this case is probably the exception rather than the rule.

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