

European Federation of Neurological Societies

Glasgow, UK, 2-5 September, 2006.



Apparently, when Glasgow was awarded the 10th EFNS Congress back in 2001, Professor Ian Bone, the Chairperson of the Local Arrangements Committee, guaranteed that it would not rain for the duration of the conference. In the event, this prediction failed, perhaps unsurprisingly, to come to fruition, but the intermittent wet weather failed to dampen delegates' enthusiasm for a meeting, based at the Scottish Exhibition and Conference Centre (SECC), which delivered in so many other ways (the exhibition even featured a stand devoted to ACNR!).

It all started with the EFNS President, Dr Jacques de Reuck, speaking on the medical intervention which has saved most lives – the condom – followed by Professor Graham Teasdale, current President of the Royal College of Physicians and Surgeons of Glasgow (RCPSG) speaking on the Glasgow Coma Scale, first published by himself and Bryan Jennett in 1974. He drew the important distinction between use of the Scale in monitoring individual patients over time, and the use of the Score (range 3-15) in summarising series of patients and for use in protocols and guidelines. The assembled delegates were then led by a pipe band out of the SECC to cross the River Clyde via Bell's Bridge to the Glasgow Science Centre for the welcome reception.

Of the many communications presented over the subsequent three days, items attended to by the current reviewer and judged of note included the following (with apologies in advance to those whose particular interests encompass multiple sclerosis, headache, stroke, neuro-oncology, etc):

Movement Disorders: a satellite symposium examined the place of dopamine agonists in the treatment of Parkinson's disease. In response to concerns about gambling behaviour associated with dopamine agonists, Professor Warren Olanow (New York) stated that since 3% of Americans have a gambling addiction, the small numbers of PD patients reported in published case series may simply reflect population prevalence and not be specifically treatment related. However, a poster from Professor Donald Grosset (Glasgow) reported that around 10% of patients prescribed dopamine agonists in West Scotland have problematic gambling. Professor Niall Quinn (London) delivered a clear and clinically useful account of atypical parkinsonian disorders: suggested red (or pink) flags for a diagnosis other than idiopathic Parkinson's disease included absence of tremor or rigidity, young onset, symmetrical onset, early freezing or falls, rapid progression, poor L-dopa response, and early dysautonomia, speech and swallowing difficulties, and dementia.

In a main topic session devoted to gait disorders, Professor Jose Masdeu (Pamplona, Spain) presented some fascinating clinico-radiological correlations, including lesions of the thalamus (thalamic astasia), thalamocortical white mat-

ter, and mesial frontal lobe, all of which affect physiological gait control systems (the 'automatic pilot'). Professor Thomas Brandt's lecture on vestibular gait disorders was, as ever, challenging for those less than au fait with the extensive ramifications of the vestibular system, but it was interesting to see the role his dog, Tessa, played in showing that running can be better than walking with unilateral vestibular failure. The possibility that walking may slow cognitive decline (N Giladi, Tel-Aviv, Israel) heartened those of us allergic to running.

Epilepsy: the provocative title 'Can genetics help us to understand and manage common neurological diseases?' was sufficient to draw some delegates from their beds early on Sunday morning. For those not initiated in the art of genetics, it was reassuring to learn that 'careful phenotyping is the key to any genetic study' but it was less reassuring to hear that a wide phenotype may be seen with the same gene mutation in a single kindred (SM Sisodiya, London). Nonetheless, the ability to identify genetic polymorphisms which determine responsiveness to certain anticonvulsants may be of practical relevance in the clinic (NW Wood, London). In a satellite symposium, I heard for the first time the term "pseudointractable" used to describe patients not responding to certain anti-epileptic drugs which do not work well in idiopathic generalised epilepsies (S Benbadis, Tampa, USA).

Sleep disorders: in a satellite symposium entitled 'Sleeping with CNS Disorders', Professor Colin Espie (Glasgow) declared that "Sleep is of the brain and for the brain". The frequency of sleep disturbance in fibromyalgia was discussed, along with the possible therapeutic use of pregabalin. Its effect on sleep may be independent of an analgesic effect (D Rowbotham, Leicester). Restless legs syndrome also merited a satellite symposium, and 'Movement disorders and sleep' was the title of a lecture accompanied by some startling and amusing videos of polysomnographic studies (C Trenkwalder, Kassel, Germany).

Dementia/neuromuscular disease: a very well attended focused workshop examined the emerging field of encephalopathies associated with voltage-gated potassium channel (VGKC) antibodies, co-chaired by Professors Angela Vincent and Martin Rossor. Since VKGC antibody-mediated non-paraneoplastic limbic encephalitis (NPLE) may easily be misdiagnosed as dementia, and most patients are over 50, the condition may well be underdiagnosed. Marked recovery from NPLE may be seen after immunotherapy, although spontaneous improvement has been recorded. Patients may be left with a retrograde amnesia extending prior to the acute illness, prompting a suggestion from the floor that the rare syndrome of focal retrograde amnesia might possibly be



causally related to missed VKGC antibody-mediated NPLE in some cases. Angela Vincent also chaired a satellite symposium on targeted immunomodulatory therapy in the management of myasthenia gravis, which included a clear exposition on the various subtypes of MG (Ian Hart, Liverpool) and a masterful account of the deficiencies of the evidence on which to base therapeutic decisions in MG by Renato Mantegazza (Milan).

Neurohistory: Delegates not only had the opportunity to hear of the work of Sir Robert Carswell (Rachel Thomas, Glasgow), but also to see it on display: the Neurohistory Tour included a visit to the Special Collections Department at Glasgow University Library where Carswell's Pathological Anatomy of 1838 was on view, including the celebrated Plate IV Figure 4, thought to be the first illustration of the lesions of multiple sclerosis. Also to be seen were copies of such celebrated works as Vesalius' De Fabrica of 1543 and Willis's Cerebri anatome of 1664; a copy of the latter was also on display at the RCPSG, the final stop on the history tour, as was an operating table used by the celebrated neurosurgical pioneer Sir William McEwen who worked in Glasgow. Another of his operating tables was seen at the Hunterian Museum, where the tour commenced, along with some of his and William Hunter's gruesome surgical specimens.

Neurology and Art: Richard Briers co-hosted a special session entitled 'The Good Life' which included: a piano recital from a lady with Parkinson's disease whose condition had been transformed by deep brain stimulation; the small bagpipes played by a man with finger dystonia; and songs from a lady with multiple sclerosis. Their fortitude and skill in the face of these disabling conditions was truly inspirational for all those whose aim is to understand and ameliorate neurological disease.

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7th European Congress on Epileptology

Helsinki, Finland, 2-6 July 2006.

A banquet of epileptology was served up in a sun-bronzed Helsinki in early July, in the ILAE 7th European Congress on Epileptology. Sessions ranged from the highly clinical to fundamental basic science, and included symposia with a local Baltic flavour, notably one dedicated to Unverricht-Lundborg disease (commonest in Finland, where the incidence exceeds 1 in 20,000).

With approximately 30% of patients resistant to currently available anti-epileptic drugs, novel pharmaceutical approaches are being sought. H Potschka (Hanover) discussed efflux-transporter mediated pharmacoresistance, and how efflux across the blood brain barrier might be reduced. Could drug delivery be targeted to the epileptogenic zone, so avoiding systemic drug side effects? This intriguing subject was elegantly addressed both by H Cock (London) and P Boon (Ghent), while A Vezzani (Milan) and D Boison (Portland) discussed respectively, focal gene therapy for epilepsy and techniques for

local augmentation of (anti-epileptic) cortical adenosine levels.

While new therapeutic methodologies are of future interest, the lack of evidence to guide current prescribing practice was highlighted. P Ryvlin (Lyon) explored selection of the first AED in partial epilepsy. According to recent ILAE criteria for robust evidence in epilepsy monotherapy, there are only four class 1 and two class 2 trials published to date! The problem of rational drug choice in IGE is even worse given the paucity of IGE drug trials (B Schmitz, Berlin). Attempts to fill this evidence vacuum were discussed, notably by A Marson (Liverpool) who described the findings of SANAD, the largest ever randomised trial in epilepsy, with 2443 patients.

What of the noble goal of preventing acquired epilepsies from developing in the first place? In her inspirational talk A Pitkanen (Kuopio) dissected past failings and current prospects for drugs to modulate the neuronal reorganisation underpinning epileptogenesis

following acquired brain insults. G Holmes (Dartmouth, New Hampshire) emphasised the need for surrogate markers of epileptogenesis (particularly MRI or EEG changes), to make antiepileptogenesis trials in humans more feasible.

Other highlights were insightful discussions of ictal and interictal autonomic dysfunction and its links to SUDEP, recent developments in epilepsy genetics, imaging and pre-surgical evaluation including the vexed question of whether low IQ is a contraindication to epilepsy surgery (consensus: it isn't).

With more than 1000 presentations, one can only convey a flavour of the feast, so my apologies for numerous distinguished omissions. I left refreshed by the event, the Finnish hospitality, and swims in the sea, which I was delighted to find was warm rather than – well – Baltic.

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28th International Congress of Clinical Neurophysiology

Edinburgh, UK, 10-14 September 2006.

One day all conferences will be like this! Comfortable chairs with masses of legroom, plentiful coffee and lunch without queues, seamless presentations because of the IT support...it all makes a difference. Well over 1000 delegates from across the world were treated to a superb scientific programme in the excellent facilities of the Edinburgh International Conference Centre. With up to six parallel sessions over four days it was impossible to attend more than a fraction of the presentations, so I shall share a couple of highlights.

Keynote lectures were almost uniformly superb, with the flashiest presentation going, somewhat predictably, to Evan Snyder (La Jolla, USA) for his overview entitled 'What Can Stem Cells Do Now?', starting with a spoof (I think) video advertising 'stem cell lager' – repairs your

liver while you drink! He took great pains to remind us that stem cell treatment is not all about replacing neurons, and that some promising results suggest that they can reduce host scarring and inflammation in the CNS, allowing the process of self repair.

Mary Reilly (London, UK) gave a useful overview of how to think about inherited neuropathies – a terrifying and confusing subject for most of us. It seems we're back to calling them CMT's, not HMSN, for now. First, work out the inheritance if possible (AD, AR, X-linked or sporadic). Next, use neurophysiology to determine whether they are primarily axonal or demyelinating (upper limb motor conduction <38m/s suggests CMT1, >38m/s CMT2, and remember the intermediate form with, for example, connexion 32 mutations and patchy conduction 25-45 m/s). Third, and finally, go

for the gene: for autosomal dominant CMT1 go first for PMP-22 then P0, whereas if autosomal recessive there are lots of genes, and you'll be lucky to find the culprit. The problem is that one gene can cause lots of phenotypes, and one phenotype can be caused by a number of genes (that's my excuse).

Eric Stålberg (Uppsala, Sweden) talked about jitter measurements when performing SFEMG, reminding us that it is best measured between two single unit potentials (ideally with interpotential interval over 300s). If, in fact, one is a compound motor unit potential, comprising say 2-10 single units, the jitter will be underestimated by a factor of up to $\sqrt{2}$. Furthermore, he pointed out that disposable concentric needles (commonly used in the UK with fears of CJD) will slightly under-detect jitter compared to single fibre needles.



Prof Jonathan Cole President BSCN presenting Prof Tony Barker (BSCN Geoffrey Parr Lecturer) with a gift after his lecture.



L-R - Robin Kennett, Ian Smith - Treasurer, Jonathan Cole - Convenor and Chair of the ICCN, Nick Murray, Kerry Mills - Chair of the Scientific Committee and Roberto Guiloff.

Shawn Bird (Philadelphia, USA) gave an excellent talk about the use of direct muscle stimulation and conduction studies in patients on the intensive care unit. It is common not to be able to record voluntary activity on routine EMG in patients with suspected ITU neuropathy/myopathy, and the presence of spontaneous activity is not really helpful in distinguishing the two. Furthermore, sensory potentials are frequently absent due to oedema, or are unrecordable due to artefact. In this situation, if a neuropathy dominates then the response to nerve stimulation (recording with a needle in the muscle) will be poor, but direct muscle stimulation much better (by a factor of 2+). On the other hand, if a myopathy dominates then the muscle potential, although small, will be equal (approximately) in response to both nerve and direct muscle stimulation.



There were many excellent 'CNS' presentations on epilepsy, MEG and so on. In a useful workshop on focal epilepsy Alois Ebner (Bielefeld, Germany) reminded us of recent work suggesting that patients with temporal lobe seizures may not require pre-operative video telemetry provided their inter-ictal EEG, clinical seizure semiology

and MRI findings all correspond, and there are no psychiatric contraindications. This theme was echoed in a poster presented by Catherine Scott from the Queen Square group.

So, overall an excellent meeting held during a Scottish 'Indian summer' (plus a day of monsoon of course) – so hot in fact that during the Scottish Evening Dinner and Ceilidh, held in the stunning surroundings of the Royal Museum of Scotland, I seriously considered a swim in the ornamental carp ponds. The miniature and huge Ron Mueck sculptures on display ten minutes walk from the conference centre provided another excellent lunchtime distraction. I look forward to the next ICCN – four years from now, in Japan.

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6th Annual Brain Injury Legal Seminar

London, UK, September 2006.

This annual event developed from a partnership between the Brain Injury Social Work Group and Stewarts Solicitors Personal Injury division.

The seminar attracted a diverse audience and a range of eminent speakers. Those planning the day succeeded in focusing on the topical issues that challenge the provision and delivery of support services to brain injured people and their families. The presentations shared by the speakers updated our knowledge, guiding us through the complex legal framework of personal injury law, public law and case law.

In terms of day-to-day practice and problem solving the session about 'Who Pays' dealt with the complexities of health and community care law and charges for services. Disclosure of records for legal proceedings was relevant for employees of NHS Trusts, social services and other public servic-



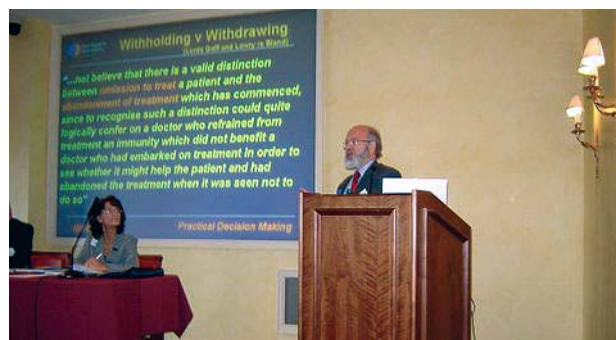
es, providers of rehabilitation and providers of care.

An experienced case manager described her role, supported by a legal opinion, about the value of case managers in personal injury claims.

Two of the sessions covered contrasting and controversial subject currently gaining extensive media exposure: Following the case of Tony Bland, the speaker shared considerations in practical decision making before withholding and withdrawal of treatment for people in a persistent vegetative state, issues for both relatives and members of the multidisciplinary team. Compensation for victims of 7/7, victims of terrorism and crime rounded off this interesting day.

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Brain Injury Social Work Group



Patti Simonson, Chair BISWG (left) and Professor Keith Andrews, Director of the Institute of Neuropalliative Rehabilitation, Royal Hospital for Neuro-disability, London.



Paul Paxton Partner, Stewarts Solicitors (left) and Patti Simonson, Chair BISWG.

Association of British Neurologists Autumn Scientific Meeting

London, UK, 4-6 October, 2006.

In contrast to the backdrop of 'fairy lights and the faint bark of seagulls' experienced at the Spring Scientific Meeting of the Association of British Neurologists (ABN) (see ACNR 2006;6(3):35), the bright lights of the capital and the faint bark of the London cabbie set the scene as delegates assembled at the Royal College of Physicians of London for the Autumn Scientific Meeting of the ABN. As always, the main focus of the start of the meeting was to catch up with old

friends and colleagues from across the country over lunch resulting in a friendly and lively atmosphere and animated conversation.

The first scientific session opened with a stimulating series of presentations on neurodegeneration including a description of the use of ¹¹C-PIB positron emission tomography demonstrating increased amyloid deposition in the brains of subjects with amnesic mild cognitive impairment associated with a higher risk of converting to

Alzheimer's disease (Dr Okello). Dr Merrison gave a fascinating presentation on the myogenic potential of bone marrow derived stem cells and the implications this may have for cellular therapies in the future. Dr Pal concluded the session by revealing that the MRC Prion Unit has developed a monoclonal antibody demonstrating strong immunoreactivity to post-mortem brain tissue from variant CJD with the tantalising possibility of a future screening test for vCJD. The ensuing

symposium examined the mechanisms of neurodegeneration with stimulating presentations from Profs. Shaw, Lovestone, Perry and Brooks.

The evening symposium on Movement Disorders chaired by Prof Quinn and Dr K.R. Chaudhuri comprised an overview on restless legs syndrome, an update on dystonia eruditely delivered by Prof Bhatia and a series of video cases of unusual movement disorders. After an inspiring first day, delegates then repaired to the welcome reception for a restorative glass or so of wine and what seemed like an endless supply of canapés.

The following day the Epilepsy and Multiple Sclerosis scientific session told us of a functional MRI paradigm that may help predict the degree of memory loss after epilepsy surgery (Dr Powell) and an update in the use of Campath 1-h (Dr Hirst) and natalizumab (Dr Giovannoni) in MS. We then moved into the 'Top Scoring Papers' session which comprised an outstanding series of presentations, including a discussion of the syndrome of transient epileptic amnesia (see also ACNR 2006;6(4):13-14), an update on the Scottish Neurological Symptoms Study from Dr Stone and an outline of the clinical features of dysferlinopathy. Prof Wiles gave us data on the outcome of MiniCEX and DOPS assessments for trainees in neurology emphasising the importance of multiple assessments carried out by multiple assessors and highlighting the value of observation and feedback in improving the evaluation of a trainee's performance.

Dr Tengah provided feedback from the pilot Knowledge-Based Neurology Exam and revealed the uncomfortable news for consultants that they had not quite matched the 100% pass rate achieved by the year 5 SpRs. The value of protecting the integrity of consultants' supporting professional activity sessions therefore seems proven!

One of the highlights of the meeting was the presentation of the ABN medal to Professor



Richard Hughes for his prolific work on peripheral neuropathy, including a citation by Dr Michael O' Brien. Prof Hughes gave a comprehensive and stimulating outline of our previous and current knowledge of diseases of peripheral nerves and a glimpse into the future about where we might be in 2037.

The meeting continued with a lecture from Prof Wessely on Gulf War Syndrome and as always the clinicopathological conference was well attended and stimulating. The conference dinner at Middle Temple was outstanding but led to a few fatigued faces on the final day of the con-

ference. The closing sessions were an eclectic mix of interesting case presentations, (with the presentation prize passing to Dr MS Jones for an unusual case of rat lungworm meningitis), followed by a discussion of what the future holds for the world of neurology in terms of medical politics, imaging and an increased knowledge of the genome. The meeting concluded with a debate in which 'This house believes that common and chronic neurological conditions are best managed by general practitioners' which perhaps unsurprisingly was overwhelmingly voted against by the ABN both before and after the debate. Encouragingly, however, most felt that the way forward was increased collaborative working between primary and secondary care.

The organisers of the Autumn meeting, Prof Christopher Shaw and Dr Robert Weeks, are to be congratulated on an outstanding achievement. As always the ABN meeting was a superb mix of high quality scientific papers, outstanding lectures from keynote speakers, the opportunity for discussion at the CPC and debate, the chance to conduct some of the business of neurology with the ABNT and Programme Directors meetings, interaction with our colleagues in the pharmaceutical industry and importantly to socialise with old and new friends within our field. It was also heartening to see so many new consultants and trainee neurologists attending (including senior house officers) showing their enthusiasm for what has to be the most fascinating of medical specialities. The support of our junior colleagues is crucial to the ongoing survival of the Association of which we are all so justly proud and we look forward to welcoming more of them at future meetings.

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