

If you would like to review books for ACNR, please contact Andrew Larner, Book Review Editor, c/o rachael@acnr.com

## Understanding Neurology – A Problem Orientated Approach

In the veritable forest of publications to bring neurology to students, and vice versa, another sapling springs forth. Whether it will survive and find a niche time & sales will tell but I doubt it will be the last on the subject. The authors have wrestled with an old problem. Clinically orientated neurological information is relevant and interesting, fun to learn, easy to retain, and makes you look good at the bedside. But it is based on preclinical neurological information which for some poor souls can be less fascinating, seldom fun to learn, hard to retain, and producing it could make you look either sad or a swot. This offering of a “problem-orientated approach to the commonly presenting complaints seen by neurologists” is an admirable effort to get the balance right.

Thirteen contributors, a dozen working in Glasgow and one representative from the not-so-soft South (Essex) take us through familiar territory with 11 pages on history taking (of which half concerns cognitive neurology). This is supplemented throughout the book by excellent subsections on “focused” history taking which serve to highlight the immense and undiminished diagnostic potential of this clinical art which, though seemingly less appealing to those who feel diagnosis can be achieved by just ordering a scan or two, survives (and even excels through the unlikely persona of Hugh Laurie as Dr Greg House; Channel 5US – don’t miss!). Indeed one doesn’t have to wait long for the first brain scan (five pages in). Furthermore, the second chapter - neurological investigation, runs to 35 pages perhaps underpinning sentiments expressed that “the advent, easy availability, and low risk of cross sectional imaging have undoubtedly diluted clinical skills...the current danger is that of over –investigation and that clinical skills are reduced such that investigations are targeted to the wrong site or incidental imaging findings are mistaken as relevant.” And don’t neurologists, increasingly invited to extinguish the fireworks ignited by ill-advised colleagues doing ill-advised tests (“just to be on the safe side / reassure the patient” / insert your own pet hate phrase) know it! Perhaps a section on the pitfalls of investigation, “When scanning is a bad idea”, may come one day. The radiological images in this book are appropriately illustrative with a valiant effort to explain how MR actually works, still a mystery to me. Again a “pitfalls” or “incidentaloma” section would, I think, be very informative. I was surprised to read in the spinal cord section of this chapter that the spinal cord ends at L2/L3. I have always thought & taught it to be a space higher, as do later authors in this book.

The neurophysiology section is informative in a qualitative if not quantitative way.

A few more problem-orientated “peripheral” cases to illustrate the values (& pitfalls) of these tests would enable normative data to be included and bring what can appear a rather dry subject to its appropriately vibrant status.

And so to “The Problems” which constitute  $\frac{3}{4}$  of the book and this bit I liked a lot.

Divided into five subsections with disorders of consciousness including acute confusional states, (with inevitable overlap with), cognition, special senses (vision, dizziness & vertigo, with inevitable overlap with), a seminal chapter on “motility” (incoordination, weakness, movement disorders), and finally “sensation”

(headache, neck pain & back ache, numbness & tingling).

Cognition features a lot in this book which is no bad thing given the high prevalence, imperfect understanding not wholly confined to juniors, and undeniably neurological nature of dementia. As in all sections the end of chapter cases help make it relevant and demonstrate how knowing stuff helps. An additional nod to the problem-orientated nature of life in the clinic would include a bit more on helpful clinical pointers that differentiate those worried well with “short term memory” problems that are not dementing, but attend neurology clinics in ever increasing numbers, from those who are.

The sections on vision and vestibular disorders are awash with illustrative cases and more digestible and enjoyable for that. A few quibbles if I may: do patients with parietic eye muscles really tilt their heads “away” from the direction of the parietic muscle to minimize diplopia?; an explanation of why only the first division of V is affected in cavernous sinus lesions despite two diagrams showing that both first & second divisions can be found there would be informative. These are minor, if important, points.

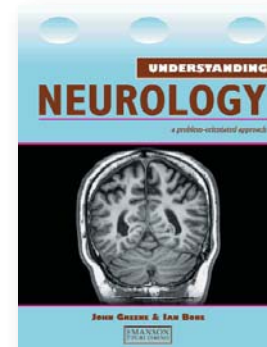
The “dizziness & vertigo” and “motility” sections both make the obvious but crucial point that many patients referred to neurology with neurological symptoms have diseases outside the nervous system. This cannot be overemphasised in our era of subspecialisation. Again a few quibbles detract somewhat from what are in many ways well written sections. Hip flexion appears in the L1, 2 myotome and also L4; knee flexion appears as an L5 root phenomenon and an S1 phenomenon two pages later; and whilst many would argue the value of the incorrectly named “supinator” jerk I’m not sure it is yet timely to exclude it completely from “Reflexes routinely tested,” especially if the finger jerk (admittedly more useful but surely less widely known at junior level) is included. A later table of reflexes & roots would seem to concur. Also (sorry to go on but..) a table listing what distinguishes UMN & LMN problems that proceeds - power, tone, reflexes, plantar responses, bulk - would jar with many of my more particular colleagues (and to be honest, me too).

The well written movement disorder section included some functional images which always provide visual relief if not pleasure. I now know that Froment (assuming it’s the same docteur) has two signs, the other one being accentuation of muscle tone with contralateral limb activity. Done it for years & never knew it had an eponym – ah, the joy of learning!

The final two sections on spinal symptoms and numbness & tingling show how just much useful information can be crammed into 24 pages – with pictures and tables (one even duplicated in case you missed it five pages previously!) included.

Perhaps one should accept that whilst demystifying neurology remains an urgent necessity amongst trainees, the development, acquisition and retention of such skills cannot exist without a solid grounding of neurological knowledge, which informs knowing what questions to ask, and why. This book strives with some success to achieve this educational balance. A touch of editorial rigour would go a long way, too.

Andrew Larner, WCNN, Liverpool, UK.



Authors: John Greene and Ian Bone

Published by: Manson Publishing

ISBN: 978-1-84076-061-3

Price: £24.95

If you would like to review books for ACNR, please contact Andrew Larner, Book Review Editor, c/o rachael@acnr.com

## Dizziness – A Practical Approach to Diagnosis and Management

“There can be few physicians so dedicated to their art that they do not experience a slight decline in spirits on learning that their patient’s complaint is of giddiness.” Bryan Matthews’ famous quote (Practical Neurology, 3rd edition. Oxford: Blackwell, 1975: 76), recently paraphrased in these pages by John Bowen (ACNR 2007; 7(2): 19), is familiar to many neurologists. But what is it that causes the spirits to sink? The complex neuroanatomy of the vestibular systems? A feeling that ENT surgeons rather than neurologists should be dealing with the problem of dizziness (they often send patients our way, so perhaps feel the converse)? The concurrence of psychiatric symptoms which may perhaps “drive” the complaint of chronic dizziness, as in chronic headache?

This well-produced volume in the Cambridge Clinical Guides series is a symptom-oriented text accompanied by a CD-ROM with 45 clips by two well-known neuro-otologists whose target audience includes any doctor called upon to assess dizziness, hence primary care physicians and A&E doctors as well as neurologists and ENT surgeons. They hope to make clinicians more optimistic when approaching these problems.

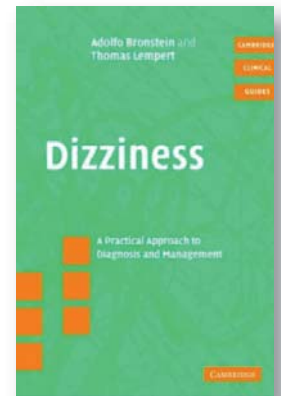
Introductory chapters on anatomy, symptoms and examination are followed by specific symptoms: acute single episode vertigo, recurrent vertigo, positional vertigo, chronic dizziness, falls in the elderly, concluding with notes on vestibular rehabilitation. The importance of clinical history taking and examination, especially of eye movements, is emphasized throughout. The fact that “vestibular function tests” generally address only one-fifth of the vestibular system (2) may explain the common scenario (Clin Otolaryngol 2007;36:217-8) of the dizzy

patient referred from ENT to neurology to exclude a central cause because “vestibular function tests are normal” yet whose history and examination suggest a peripheral origin for symptoms. Migrainous vertigo seems underdiagnosed as a cause of recurrent vertigo and Meniere’s overdiagnosed (30). The intimate connection of vestibular and psychological symptoms (anxiety, panic, depression, somatisation) is addressed (117-24). The concepts of vertebrobasilar insufficiency (10) and cervical (28,185) or head extension (153-4) vertigo are debunked, and the lack of utility (low specificity) of the hyperventilation test pointed out (123,169). Betahistine does not feature in the list of “10 common vestibular suppressants and antiemetics” (209-12), despite the frequency with which it is used in the patients reaching my clinic.

This is a pragmatic text, steeped with the authors’ experience. I have few quibbles: it would have been desirable in the index of videoclips (xii-xiii) to cross reference the text where they are discussed. I foresee circumstances in which the recommendation a propos chronic dizziness to “send a few too many patients for neurological consultation” (171) might be misconstrued by an enthusiastic ENT SpR or GP trainee with rather significant consequences for local neurology outpatient clinics. A 70% hit rate for the aetiology of peripheral neuropathy (181) seems optimistic.

Short of having Adolfo Bronstein universally available to sort out dizzy people, this book is a very acceptable addition to a neurologist’s armamentarium for dealing with a common clinical problem.

*AJ Larner, WCNN, Liverpool*



**Authors:** Adolfo M Bronstein and Thomas Lempert  
**Published by:** Cambridge University Press  
**ISBN:** 0-521-83791-X  
**Price:** £35.00

## Neurological Disorders in Famous Artists (Part 2)

The visual arts seem to predominate in this second volume of neurological disorders in famous artists from the Karger Frontiers of Neurology and Neuroscience series. The effects of both neglect and of aphasia on visual artistic output are examined (Blanke), the former mostly after right hemisphere stroke (Bazner & Hennerici x2), for example in the painter Lovis Corinth and the film-makers Visconti and Fellini (Dieguez et al), the latter after left hemisphere stroke, for example in the painter Reutersward (Colombo-Thuillard & Assal). The high quality illustrations support the various authors’ theses. A possible depiction of sleep paralysis in a painting by Fussli (Baumann et al) is also presented.

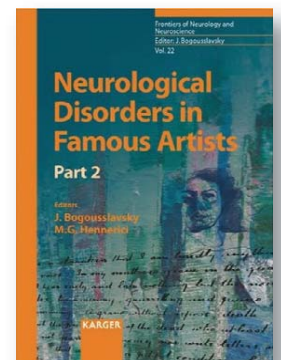
There are several chapters of straight pathography: Proust (Bogousslavsky) did not clearly have any neurological ailment although his asthma was regarded as a “nervous” disease, not least by his medical father, and he consulted Babinski amongst many others; Heine (Auf der Horst), a victim of syphilis; Baudelaire (Dieguez & Bogousslavsky) developed aphasia with recurrent utterances. Musicians are in a distinct minority: von Bulow (Wohrle & Haas) is best known for being cuckolded by Wagner but had additional problems, not least occipital neuralgia and strokes. The evidence for and against Mozart having had Tourette syndrome is carefully weighed and found wanting (Kammer).

The emergence of artistic behaviour following brain

injury (Pollak et al), mostly frontotemporal dementia but also in selected cases of epilepsy, Parkinson’s disease, and following subarachnoid haemorrhage, is truly fascinating. The problem of de Kooning’s late work, produced when he was suffering from Alzheimer’s disease, is reported solved (Espinell) through the development of no less than an entirely new intellectual discipline, “ArtScience”, requiring specific thinking and observation methods, all devised (single-handedly) by the author. Myself a dullard, subscribing to the Gordon Holmes approach (“Observe and describe, that’s all”), methinks this author doth protest too much! The place of synaesthesia in creativity is discussed (Mulvenna): is it a chance concurrence or over-represented in artists? Surprisingly in this context, Kevin Dann’s book, Bright colors falsely seen: synaesthesia and the search for transcendental knowledge (New Haven and London: Yale University Press, 1998) is not referenced. The discussion prompts a distinction between “creative cognition” (= having ideas) and creative output (= trying to communicate them).

As with the first volume (reviewed ACNR 2005; 5(5): 37) one can enthusiastically recommend this volume. Although not cheap, many neurologists with broader interests will be keen to have a copy.

*AJ Larner, WCNN, Liverpool, UK.*



**Edited by:** J Bogousslavsky, MG Hennerici  
**Published by:** Karger, 2007  
**ISBN:** 978-3-8055-8265-0  
**Price:** €88.00