

much improved' than those on placebo. There were no significant differences between cannabis extract and placebo groups in secondary outcomes including neurological disability, anxiety, depression and measures of cognitive function, apart from a small reduction in a selective memory test with the active treatment.

The researchers, from the Walton Centre for Neurology

and Neurosurgery, Liverpool, commented, "This is the first study to show a significant reduction in neuropathic pain and pain-related sleep disturbance in people with MS treated with cannabis-based medicinal extract."

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For an overview of the new guidelines for the management of MS, see page 26

Association of British Neurologists Autumn Meeting

1-3 October, 2003; Glasgow, UK

The educational symposium on 'neuroinflammation and neuroinfection' covered aspects of viral encephalitis, immunoglobulin therapy, immune-mediated neuropathy, and inflammatory markers in ischaemic stroke.

We were privileged to have Professor DH Miller speak on the contribution of MRI to the understanding and management of multiple sclerosis with particular reference to the McDonald criteria and potential use in monitoring of immunomodulatory treatment. Professor D Shaw delivered an outstanding lecture as ABN medallist.

A 'taster' of the conference is provided with the following short reports.

1. **PD LIFE - A prospective multi-centre longitudinal audit of quality of life in Parkinson's disease across the UK.** Chaudhuri, London and Newcastle. Preliminary results; In 95 patients with early disease after 10 months 65% are on monotherapy (58% L-dopa; 38% dopamine agonists), and dopamine agonists are rarely used in older patients. Using L-dopa or dopamine agonist made no change to the quality of life scores.
2. **Oligoclonal band negative MS – does it exist?** Joseph, Bristol. Nineteen oligoclonal band negative patients were identified from 539 cases over 6 years in this retrospective case-controlled study. Unusual features in this group included headaches, generalised seizures, depression, cognitive impairment and psychosis. A monophasic or relapsing remitting course was more likely and the majority had significant disability contrary to beliefs held that this was a benign illness.
3. **The presentation of adults with arteriovenous malformations (AVM's) of the brain: prospective, population based study.** Al-Shahi, Edinburgh, Glasgow, Aberdeen and Dundee. Ninety-two patients were diagnosed over 2 years. Incidental AVM's (21%) were found in population 2 years older than those who presented symptomatically. This group had prior history of intracranial haemorrhage in 21%, 21% had 1 seizure and 32% had epilepsy or haemorrhage.
4. **The MRC's Asymptomatic Carotid Surgery Trial (ACST) – results after 5 years follow up.** Thomas and Halliday, London. Most of the 3101 patients had over 80% carotid stenosis and were allocated to either immediate carotid endarterectomy (CEA) or deferred CEA (i.e. until patient became symptomatic). The early surgery group had a significant reduction in stroke risk. For any type of stroke the 5 year risk was 6.42% for immediate, compared to 11.75% for the deferred group. Risk of fatal or disabling stroke was 1.87% for immediate and 5.57% for deferred. Overall peri-operative risks were 2.6% (mostly strokes and cardiac prob-

lems). The benefit did not hold true for those over 75 where deaths removed the value of surgery.

5. **Abnormalities in cardiac rhythm revealed in patients with refractory epilepsy.** Simister, London. Cardiac rhythm monitoring devices were implanted into 19 patients with refractory focal epilepsy over a median 16 month period. Three of 19 patients had potentially life threatening heart rhythms including sino-atrial arrest and prolonged bradycardia requiring permanent pacemaker insertion.
6. **Functional paresis – paradoxes in illness beliefs and disability in 107 subjects.** Stone, Edinburgh. Patients with functional paresis (107), compared to those with neurologically defined paresis (46) of less than 2 years' duration were much less likely to blame stress and twice as likely to have given up work because of symptoms despite similar self-rated disability.
7. **Potassium channel antibody associated encephalitis: a potentially treatable non-paraneoplastic limbic encephalitis.** Schott, London, Oxford and Germany. Phenotypic features of 10 antibody positive patients were memory loss, confusion and seizures, with syndrome of inappropriate anti-diuretic hormone secretion in 8, and temporal lobe change on MRI in 8. Improvement with treatment varied (steroids, immunoglobulin and plasmapheresis), with definite improvement in 6, and thus mirrored a fall in antibody titres.
8. **Synthetic disialyl-galactose immunoabsorbents clear pathogenic anti-GQ 1 b ganglioside autoantibodies from serum in Guillain Barré syndromes.** Willison, Glasgow and Alberta, Canada. Development of a synthetic trisaccharide which can "wash out" the anti-GQ 1 b antibodies linked to Miller Fisher syndrome was described. Although not developed yet for patient treatment, the wider potential therapeutic applications of such a technique in antibody-mediated disease made this presentation the most exciting of the conference to these reviewers.

We were grateful to Dr R Thomas for a historical exposition in an expanded poster on Sir Robert Carswell, a Scottish pathologist responsible for the first description of the multiple sclerosis plaque. Original drawings kindly on loan from University College London were displayed. One mystery remains – the location of one of his original drawings – although a facsimile is available. If any reader can assist please contact Dr Thomas or one of the authors direct or c/o E-Mail. AdvancesinCNR@aol.com

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Walking group at the summit of Ben Lomond after the conference, organised by Prof. Willison