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## Catatonia: A Clinician's Guide to Diagnosis and Treatment

First delineated by Karl Kahlbaum in 1874, catatonia is a syndrome of motor dysregulation characterised by mutism, characteristic posturing (catalepsy, waxy flexibility), repetitive speech, negativitism, and imitative movements. In this monograph, two American neuropsychiatrists draw together their own extensive experience of the condition with that of the published literature. They detail the history, clinical features, differential diagnosis, treatments (old and new), and possible neurobiological substrates of the syndrome, which they observe to be common in acute psychiatric practice. The text is leavened with over 50 illustrative patient vignettes.

A number of themes emerge. The classification of catatonia as a subtype of schizophrenia, initially by Kraepelin and latterly perpetuated in successive editions of the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association, is criticised as being too narrow. Most catatonic patients in fact suffer from a mood disorder; neurological and general medical disorders may also manifest catatonia. Suggestions for an alternative classification of catatonia as a syndrome, in accordance with these observations, are made, possibly in hopes of inclusion in DSM-V. There is strong advocacy for treatment of catatonia with lorazepam, followed, if unsuccessful, by ECT. There is trenchant criticism of the legal barriers causing delay of ECT in certain localities. Neuroleptic malignant syndrome (NMS), which may have causes other than treatment with neuroleptic

drugs (e.g. withdrawal of dopaminergic therapies), is subsumed within the category of "malignant catatonia" (MC), as is the serotonin syndrome. Suggested treatment of MC/NMS is with benzodiazepines and ECT, as for other causes of catatonia, rather than with dantrolene and/or bromocriptine.

I found this book an interesting read, providing some insights into the often obscure territory lying in the borderland between neurology and psychiatry. Characterisation of catatonia as a syndrome with many possible causes is certainly appropriate, presumably reflecting a common neurobiological substrate, irrespective of the underlying disease process (and whether that is arbitrarily categorised as neurological or psychiatric). However, as a neurologically trained practitioner, I was not receptive to the suggestion that stiff-person syndrome and locked-in syndrome might be amenable to the same treatments as catatonia because of their clinical similarity (109), nor that echophenomena are specific catatonic features (116). Also, I suspect that evidence-based practitioners will be less than convinced by the assurance that the reported efficacy of lorazepam and ECT is not solely due to a "misleading selection of clinical vignettes" (193): I cannot recall any reference to randomised controlled trials of treatment. If the therapeutic effects are large, small trials should have adequate power to demonstrate this.

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## Neuropsychiatry and Behavioral Neuroscience

The authors open their textbook by stating that they aim to integrate a current review of the two disciplines of behavioural neurology and biological psychiatry in a single volume. This may seem to be a more than reasonable project and, as the first author is both a professor of neurology and psychiatry and the second a neuroimager, one that should be eminently achievable; however, the book largely fails on two counts. Firstly, at only 414 pages long, it is just too short to be able to deliver on its promise to "... link the recent explosion of new information from neurochemistry, neuroanatomy, genetics, neuropharmacology, neuropathology, and neuroimaging to the clinical descriptions", especially as a further aim is to include therapeutics. Thus Alzheimer's disease is allocated only three sides, and, while we all recognise that the familial forms of this disease are rare, there is no mention of Apo E or the presenilin genes in either text or index. Stroke receives even less attention with therapy dealt with in only one paragraph which is limited to clot-busting drugs and aspirin; there is no mention of rehabilitation - cognitive or otherwise.

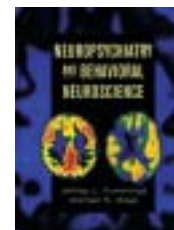
The second flaw is a more philosophical and indeed personal one. It has been lamented that Neurology and Psychiatry (surely two sides of the same coin) have drifted apart to each others' detriment and need to be reunited immediately in order to share mutually enlightening discoveries about brain function. After all, most psychiatrists would accept that the mind is an emergent property of brain function, and all neurologists have at least a passing interest in disorders of the brain. The problem is that the 'common ground' argument is perhaps most true for neuroscience research (especially neuroimaging), and least true for clinical practice. Neurologists (even behavioural ones) and Psychiatrists just don't see the same type of patients

and thus it does not necessarily follow that a clinically orientated textbook designed for both will be useful to either (for more on this debate see: Leon Eisenburg in *Neurology Today* 2002; 2(5):p.4).

Trying to mix the immiscible leads to a few jarring moments: the treatment of neuropsychiatric disorders is discussed before the principles of neuropsychiatry are laid down; apraxia and acalculia are dealt with in the chapter on speech and language disorders; traumatic brain injury and CNS infections pop-up in the chapter on focal brain disorders. But there are parts of the text where this approach reaps rewards. The chapters on memory disorders and hallucinations both start with clear definitions and then move neatly between 'psychiatric' and 'neurological' causes for these difficult and complex symptoms which often confront clinicians on ward consults or in the out-patient clinic. The former chapter also has a good summary of the more recent functional imaging work on memory encoding and storage. Other hidden gems include the best taxonomic system for the classification of aphasic syndromes that I've come across in a textbook and a nice comparison between the disordered speech output seen in Wernicke's aphasia and schizophrenia. The selection and quality of illustrations is high throughout.

This textbook is probably best dipped into by neurologists who want to know a little bit more about psychiatry, and psychiatrists who want to know a little bit more about neurology; but until neurologists start treating psychoses and psychiatrists start thrombolysing stroke, any clinically based text aimed at both specialists is going to appear uneven in both scope and detail.

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## Cerebrovascular Ultrasound in Stroke Prevention and Treatment

This book has been produced by an international team of contributors, edited at the University of Texas and is aimed at three types of individuals: beginners to learn the basics of ultrasound testing, advanced users to learn differential diagnosis and clinicians involved in treating stroke patients. The text is packed full of useful practical information and has excellent illustrations and TCD images. However, the content is not basic and beginners wishing to start TCD would be advised to read simpler texts prior to this book. It is divided into five parts: Part I-*How to perform ultrasound tests* covers both extracranial and intracranial ultrasound examination with an emphasis on standardisation for carotid duplex. The techniques for carrying out single-gated spectra (TCD), power-motion Doppler (M-mode) and transcranial colour duplex imaging (TCCS) are outlined in a simple and clear manner. The advantages of M-mode (easier window-finding) and TCCS (identifying anomalies of the circle of Willis) for the beginner are emphasised but the caveat for both M-mode and TCCS is spectral resolution and it is acknowledged that experienced operators will still use single-gated TCD. Part II-*Haemodynamic principles* is a "heavy" section but will be of particular interest to anyone working in the intensive care/surgical setting. The chapter on practical models of cerebral haemodynamics impor-

tantly emphasises spectral waveform recognition rather than the usual emphasis on velocity. Part III-*Criteria for interpretation*. is an excellent section covering diagnostic and validation criteria for carotid stenosis, carotid and vertebral artery dissection and occlusion, intracerebral arterial vasospasm, embolism detection, with a good description of the TIBI ultrasound classification for large vessel occlusion. Part IV-*Ultrasound in stroke prevention and treatment* covers ultrasound findings of specific diseases including sickle cell disease, cardiovascular risk, secondary stroke prevention, acute ischaemic stroke, subarachnoid haemorrhage. The chapter on ischaemic stroke discusses the potential therapeutic use of TCD and is well worth reading. Part V-*Select clinical applications and clinical vignettes* includes an interesting collection of anecdotal vascular cases covering areas which can give diagnostic difficulty. The exciting parts of this book have to be the emphasis on the potential therapeutic use of diagnostic TCD and the focus on waveform analysis rather than velocity measurements. This opens up TCD as a bedside tool, which will hopefully mean that more clinicians will start using this powerful technique.

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