Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

Localization in clinical neurology

In his essay, Dr Shafqat (December 2005 *JRSM*[1]) takes the view that the advent of modern neuroimaging has liberated neurology from the 'shackles of cerebral localization'.[1] My experience is exactly the opposite—it has reinforced even more strongly the importance of clinical localization in neurology. It is our ability and confidence in appropriate clinical localizations that allows us not to recommend a magnetic resonance imaging brain scan for every patient with headache and dizziness. Surely, one would not change the clinical diagnosis of migraine even if the brain scan revealed an incidental lipoma or small area of calcification.

Dr Shafqat also suggests that emphasis on anatomical localization has hindered the development of therapies in neurological diseases 'including epilepsy, migraine, Guillain–Barré syndrome, Parkinson's disease, multiple sclerosis and ischaemic stroke'.[1] It is probably not true. The diagnosis of idiopathic epilepsy, migraine and Parkinson's disease still remains clinical, and neuroimaging would not be normally expected to change it. Effective therapy for these conditions was available before modern neuroimaging and levodopa remains as the gold standard for the treatment of Parkinson's disease. Aspirin is still widely used for ischaemic stroke, and warfarin in fewer cases—both of which are very old treatments. Neuroimaging is not necessary in order to diagnose Guillain–Barré syndrome and, with few exceptions, treatment can be initiated after clinical examination alone. I agree that the MRI scan has helped with the diagnosis of multiple sclerosis—but is there an efficacious treatment for it yet, other than the corticosteroids? I am not so certain.[2]

I believe a neurologist who can happily spend 3 days examining a patient for challenging anatomical localization will also be able to make a correct diagnosis under 3 minutes in acute stroke. The most important outcome of a neurological examination is anatomical localization. I can only hope that Dr Shafqat will agree.

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Localization in clinical neurology

Dr Saad Shafqat is incorrect in his assertion that localization in clinical neurology has been rendered outmoded by advances in technology.[1]

The advances of modern neurology are built on the assumption that the neurologist can make the correct diagnosis. We were present when one of the first computerized tomography scans of the brain was performed in the 1970s. Upon seeing these first clear images of the brain, Dr Raymond Adams declared that we were witnessing the introduction of a new tool into clinical neurology. That has certainly proved to be true, but imaging is still just a tool. The treatments for neurological disease that we now possess are also not ends in themselves. They are only part of the continuous, gradual development of knowledge about the nervous system needed to solve the really big problems in clinical neurology (e.g. epilepsy, paralysis, dementia, neoplasia, degenerative disease, and stroke).

The fundamental problem that arises in degrading the examination is that all clinical analyses risk starting from the wrong point. Mistaking weakness for ataxia, tremor for seizure, functional paralysis for genuine paralysis, root pattern sensory loss from that of nerve or spinal cord, aphasia from psychosis, dystonia from joint limitation, coma from catatonia, hip arthritis from lumbar radiculopathy, apraxia from confusion: not to mention distinguishing the various types of gait and dysarthrias, create endless and misplaced testing, the results of which are as useful as the original mistake in interpretation.

In our current practices, much of what we do is to take a careful history, examine the patient and put into proper perspective all of the imaging, genetic and other laboratory testing that may or may not bear on the patient's problem. Experienced experts can learn to apply the principles correctly yet rapidly in order to conform to the time

constraints of modern neurological treatment. To abandon the principles of the neurological method is to risk transforming our learned profession into a rote trade.

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Depression: epidemic or pseudo-epidemic?

D Summerfield (March 2006 *JRSM*[1]) reports that the epidemiology of depression is difficult as emotion is understood differently in Eastern and Western cultures.

Emotion is a word that presents difficulty for us all. The *Concise Oxford Dictionary* records the word emotion as originating in the 16th century replacing the older word passion and that it is from the French *émouvoir*, to excite.

The taxonomy of emotions presents many difficulties; in 1872 Darwin[2] wrote only of emotional expression in man and animals. Shand in 1869[3] noted that sentiments were groups of emotions dependant on the environment. If one loved a person and something good happened to them, one was happy; if something adverse occurred, sadness resulted.

A further refinement was suggested by McDougall,[4] who in 1905 stated that moods were a tendency to primary emotion, e.g. rage or fear. Much was written in the 20th century about the lmbic system and emotion. Attempts were also made to divide emotions into primary, blended and derived—the latter are not shared with animals as they are constructed by cognitive functions.

A current view has been expressed by Carpenter,[5] who suggests that there are two basic emotions in man and animal—arousal and withdrawal. Arousal is associated with 'fight or flight' and the sympathetic system: withdrawal is associated with a range of depressive states.

It seems that human behaviour, as with other sciences, needs its own specific—a subject discussed by C P Snow (*The Two Cultures*. Cambridge University Press).

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Inadvertent toxic drug reaction in the management of atrial fibrillation

The choice of either sotalol or amiodarone for rhythm control was a feature of the management of a case presented by Leaver and Ho (March 2006 *JRSM*[1]) which was even more problematic than the inadvertent choice of adversely interacting drugs. Although amiodarone was the final choice of antiarrhythmic agent, presumably because of its superior efficacy in preventing relapse of atrial fibrillation (AF),[2] it is a drug now known to be associated with relapse rates of the order of $>90\%$.[3,4] Accordingly, so long as the long-term antiarrhythmic management of AF involves drugs, which are not strikingly superior to amiodarone in their efficacy—even with the benefit of adjunctive electrical cardioversion[3]—the verdict from the AFFIRM study[5] will prevail. In paraphrase, the verdict from AFFIRM is that failed rhythm control is a poor substitute for successful rate control.

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Public health in the UK: success or failure?

Congratulations for publishing the essay by Gray *et al*. on public health (March 2006 *JRSM*[1]). As a medical student undergoing the rigors of undergraduate medical education, public health is perceived as a triviality when compared to voluminous clinical medicine; and therefore not considered as an academic work out worthy of sweat.

Such an engaging essay has been enlightening by demonstrating that, the phrase 'prevention is better than

cure' can relate to certain fragments of our world that do not obviously connect to medical practice (e.g. seat-belt usage and the subsequent decrease in associated ward admissions).

This highlights the need for governments to create preventative methods that combat disease and injury that can be accessed by everyone (e.g. obesity needs the government to do more to change our nations thoughts surrounding food consumption and exercise).

But our nation's health is not completely dependent upon public health professionals; and such radical endeavours demand scrutiny and encouragement from everyone.

One could argue further that healthcare professionals should embody noble principles. It is paradoxical that, although smoking bans have been championed by doctors, a significant part of the workforce continues to smoke.

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Contribution of general practice to NHS patients

I commend the article by Wilson *et al.* (January 2006 *JRSM*[1]).

Regarding the equity of general practitioner provision, the authors correctly point out the under provision in some working class areas. Government policy is to introduce non-NHS providers, including multinational private health corporations. No mention is made of the former Medical Practices Committee, which stopped GPs practising in over-doctored areas, like Kensington, and gave financial incentives to doctors setting up in under-doctored areas.

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