countered in such a situation especially in the first few days and tips to differentiate the two conditions.

M. Behari, A. K. Srivastava, V. Sardana, K. Prasad

Department of Neurology, All India Institute of Medical Sciences, C.N.Centre, Ansari Nagar, New Delhi - 110 029, India.

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Satoyoshi syndrome:
Comments

Sir,
I read with interest a case report of Satoyoshi syndrome by Ashalatha et al.1 The similarity with a ‘jerking stiff-man syndrome’—a variant of stiff-man syndrome (SMS) is striking. Distal limb involvement, myoclonic jerking, board-like muscles, stimulus-evoked spasms, endocrinopathies, vitiligo, pernicious anemia and sicca syndrome can also be seen in jerking SMS.2 Continuous motor unit activity (CMUA) is necessary to diagnose this variant but can sometimes be elusive and manifest only in the paraspinal muscles.3 Earlier this year, anti-GAD antibodies were described with Satoyoshi syndrome.4 This validates the auto-immune nature of this disorder and suggests that it might be a variant of stiff-man syndrome. In both cases, a partial response to immunomodulating agents such as immuno-globulin or high dose steroids may be seen. I wonder if anti-GAD antibodies could be tested in the described case as well.

Boby M. Varkey
Mayo Clinic, Rochester, MN, USA.

References


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Authors’ Reply

Sir,
We Dr. Varkey for the interest in our case report on Satoyoshi syndrome1. We are aware of the very recent publication of Drost et al., of anti GAD antibodies in Satayoshi syndrome2. Interestingly, unlike our patient, the case reported by them did not have any of the typical features of Satayoshi syndrome such as short stature, bony deformities, glucose intolerance, jaw muscled spasms etc. which were reported by Satayoshi. But for the age of onset, the case could have easily been called stiff person syndrome, a condition where 65% patients could have antiGAD antibodies. We agree that if the test were positive in a more typical case such as ours, it would add more strength to the presumed autoimmune etiology of the condition as well as the suggestion of Drost et al., that Satayoshi syndrome and Stiff person syndrome could both be different clinical expressions of a spinal hyperexcititability state in different age groups. We will pursue the same.

R. Ashalatha, A. Kishore, C. Sarada, M. D. Nair
Consultant in Neurology, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum - 695011, Kerala, India.
E-mail: drashalatha@sctimst.ker.nic.in

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Neurosurgical training in India at the crossroads?

Sir,
The Neurosurgical Training in India at present seems to be in the crossroads. The problem seems to be many folds: 1) There does not seem to be any regulation of demand and supply, leading to underemployment and unemployment among qualified neurosurgeons! 2) There is a gross disparity between training imparted in various institutions, leading to gross difference in the quality of the Neurosurgeons produced. 3) There are the problems in training in non-teaching Private Hospitals offering neurosurgical training approved by the National Board of Examinations (NBE). These problems need to be addressed urgently by the Senior Neurosurgeons and Neurosurgical Teachers in the interest of the Profession and the Community at large.

On an average about 40 to 50 Neurosurgeons (both M.Ch. and D.N.B) are added every year in India. Though the number of neurosurgeons per population may still be low, compared to the developed countries, the non-availability of neurosurgical facilities precludes the migration of trained neurosurgeons to

Letter to Editor
Figure 1: MRI scan of the craniovertebral junction both corona (A) and axial (B) sections shows rotatory atlantoaxial subluxation with lateral mass lying adjacent to the spinal cord.

Figure 2: 3D-computed tomography (CT) scan showing right rotatory atlanto-axial subluxation without any increase in the atlanto-dental distance confirming the diagnosis of Fielding’s Type I atlantoaxial rotatory subluxation2 (Figure 2). She was treated with Gardner-Well’s skull traction and reduction

V. G. Ramesh
Institute of Neurology, Madras Medical College, Chennai - 600003, India. E-mail: drvgrur@vsnl.net

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Sir,

A 17-year-old girl presented with complaints of sudden onset of torticollis associated with severe neck pain and restriction of neck movements. There was no history of trauma. On examination, she had “cock robin” deformity of the head, which was rotated to the left and the chin was directed to the right side. There was no neurological deficit.

X-ray of the craniovertebral junction (CVJ) (open mouth view) revealed overlapping of the lateral masses causing obscuration of the lateral atlantoaxial joints. Magnetic resonance imaging (MRI) scan of the cervical spine revealed rotatory subluxation of the atlas with the lateral mass lying adjacent to the cord (Figure 1). 3D-computed tomography (CT) scan revealed Fielding’s Type I atlantoaxial rotatory subluxation2 (Figure 2). She was treated with Gardner-Well’s skull traction and reduction