reflex is unclear. However, affection of frontopontine fibers in
the anterior limb of the internal capsule and activation of the
red nucleus as an alternative pathway for transmitting corti-
cal signals to the spinal cord (corticorubrospinal pathway)
could be the cause. This could also explain the cause of trem-
ors in the right hand which increased in frequency as the hand
approached the face, as the red nucleus has a similar relation
with the cerebellum as that of the cerebral cortex with the
cerebellum.

S. Vasudeva, B. Rai, Ruchita Vasudeva
Dr. Bhagwant Rai Neurology Clinic, Circular Road, Amritsar,
Punjab, R. Vasudeva Deptt. of Physiology, Dashmesh Institute of
Research & Dental Sciences, Faridkot, Punjab, India.
E-mail: sutiksharv@yahoo.com

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Lower end of ventriculoperitoneal shunt embedding in liver parenchyma

Sir,

Insertion of ventriculoperitoneal shunt is one of the com-
monest neurosurgical procedures. Though a safe and simple
procedure, it is not devoid of complications. The common com-
lications associated with shunt surgery are blockage, infec-
tion, over-drainage and malfunction.

A 5-year-old female child had a non-communicating hydro-
cephalus. A Medtronic moderate pressure ventriculoperitoneal
shunt was inserted. After about 15 days of surgery, the pa-
tient developed headache, vomiting and low-grade fever and
mild pain in abdomen. There was referral of pain to right
shoulder. X-ray of the upper abdomen showed that the shunt
tube was coiled in the right subdiaphragmatic region. Ultra-
sound abdomen revealed a cystic cavity in the right lobe of the
liver with shunt tube inside it. CT scan abdomen (Figures 1)
was done, which showed shunt tube embedded in liver paren-
chyma and a cystic cavity around the tip of the tube. The
patient was given preoperative cover of 3rd generation cepha-
lopiorin and the lower end was taken out. The shunt tube
distal to the chamber was replaced by Chhabra MDR shunt
and reinserted through a left inguinal incision. The postop-

crative period was uneventful. She was asymptomatic at 3
months follow-up and ultrasound abdomen showed resolution
of the cyst in the right lobe of the liver.

There are numerous complications of the lower end of the
shunt described in the literature. By the above case, the au-
thors want to share their experience of this never before re-
ported complication.

Naveen Chitkara, Rahul Gupta, S. L. Singla*,
N. K. Sharma
Department of Neurosurgery and Surgery*, Pt. B. D. Sharma
PGIMS, Rohtak.

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Klinefelter’s syndrome with myopathy-A case report

Sir,

An 18-year-old male had a decline in the intellectual func-
tions since childhood. The parents also complained of epis-
odic falls and transient loss of consciousness. These episodes
occurred on an average, once in every two months, for two
years. There was difficulty in rising from the sitting posture.

On examination the patient had marfanoid features. He had
small testicles and sparse facial and axillary hair and mild to
moderately impaired cognitive functions. Except for bilateral
mild flaccidity of calf muscles, there were no other deficits.
No obvious behavioral changes were observed.

Routine laboratory investigations showed no abnormality.
EEG and cranial CT scan were normal. EMG showed myo-
pathic pattern in all four limbs. Nerve conduction study was
Letter to Editor

normal. Serum muscle enzymes were normal. I.Q score was 45.
Peripheral leukocyte culture showed change in the form of numerical aberration with 80% of divisional plats showing 47 xxy and 20% showing 46 xy.

A mosaic form of Klinefelter’s syndrome with myopathic features was diagnosed. The patient is being treated with valproate, which has resulted in reduction in the frequency of seizures.

Klinefelter’s syndrome,¹ first described in 1942, is said to be the most common sex chromosomal aberration (0.9 per 1000).² This is often associated with cognitive disorders and increased incidence of behavioral abnormalities.³ EEG shows spike wave changes.⁴ Some cases show reduction in muscle tone and neuromotor developmental delay⁵ but myopathic features are uncommon.

P. K. Gangopadhyay, Debasish Guha
Institute of Post-Graduate Medical Education and Research and Bangur Institute of Neurology, Kolkata - 700 020, India.

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