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Prospective, population based studies of cavernous malformations are needed

In their welcome systematic review of supratentorial cavernous malformations and epilepsy, Moran et al illustrate the pitfalls of regarding the prognosis of a disease in selected case series as representative of its natural history. Studies of cavernous malformation prognosis have usually lacked clear inception cohorts with respect to mode of presentation and treatment. Referral filter bias has so often restricted ascertainment by tertiary referral centres, and further selection bias has made the prognosis seem worse than it really is, as demonstrated by the authors’ own series of 33 patients in which temporal lobe lesion location and intractable seizures predominated. Conversely, by leaving community mortality unaccounted for, the prognosis can seem better than it actually is. Completeness of follow up has been variable and not always prospective. Furthermore, authors have varied in their choice of outcome, in particular their definition of haemorrhage (clinical or radiological), choice of period at risk (from birth, time of diagnosis, or start of observation) and calculation of outcomes for each patient or for each lesion. Any analyses of such heterogeneous case series should be ruthlessly systematic, but even so it is necessary to be wary about drawing firm conclusions from them.

The only existing population based study of cavernous malformations,1 albeit with a denominator of merely 50,000, was retrospective. The study spanned fundamental developments in the non-invasive diagnosis of cavernous malformations during the 1980s with magnetic resonance imaging, which led to increasing detection rates with time.

There is, therefore, clearly a need for a large, population based, prospective, contemporary epidemiological survey of cavernous malformations to establish their frequency and prognosis. With a broad collaborative network, including the three other neuro science centres in Scotland, the Scottish Intracranial Vascular Malformation Study (SIVMS) (www.dcn.ed.ac.uk/ivm/) to do just this for all types of intracranial vascular malformation (IVM). Using multiple, overlapping sources of case ascertainment we are building an inception cohort of all incident cases of any type of IVM diagnosed after 1 January 1999 in the population of Scotland (5.1 million).

With prolonged follow up of this cohort we hope to settle some of the uncertainties highlighted by Moran et al. Moreover we agree that, with such poor data available, a randomised controlled trial of surgical versus conservative treatment of cavernous malformations is overdue.

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Neurological stamp: Adam Politzer (1835-1920)

Recently I found an interesting manuscript in your journal about Adam Politzer under the section on neurological stamps. I was mildly disappointed by the presence of some inaccuracies concerning the biography of Adam Politzer, and write to you to correct these impressions.

Adam Politzer published in 1878 the first volume of his textbook of otology under the original German title Lehrbuch der Ohrenheilkunde für praktische Ärzte und Studierende. The second edition was published in 1882 to complete his work.1 Since the second edition, this textbook of otology was printed in one volume.

The finding that ossicles vibrate to sound stimuli was not made by Politzer but by Hermann von Helmholtz with his resonance theory published in 1863 completed by the mechanism of ossicles and tympanic membrane in 1868.2 Politzer was one of his students in 1861 in Heidelberg.

Adam Politzer invented, notably, a revolutionary method to make the eustachian tube permeable in 1863,3 a method which made him famous and carried his name. He also developed an acometer in 18774 to measure hearing, replacing the watch, which was used until this date.

In 1864 Politzer founded with Anton von Tröltsch and Hermann Schwartz the first German and international journal of otology under the original title Archiv für Ohrenheilkunde.5 In 1879 The American Journal of Otolaryngology6 was founded and edited by Clarence J Blake and was printed for only 4 years at this time.

In addition to more than 100 publications in medical journals, and besides his textbook of otology,7 Politzer published three other books, all translated into English. As well as one book about anatomical and histological dissection of the human ear and one about the history of otology,8 Politzer published an atlas of the tympanic membrane in 1865,9 completed and reprinted in 1896.10 Politzer was certainly the greatest otologist of the 19th century and probably one of the greatest of all time. His influence during 50 years at this time.

The text is interspersed with illustrative cases which appear in the diaries. This is followed by some chapters discussing causes of peripheral nerve injury other than focal lesions, including metabolic and physical factors and tumours. The description of the clinical syndromes is clear and succinct and well referenced throughout. The advice is sensible with a strong emphasis towards conservative management with clear statements as to when more rapid intervention is needed.

The authors say that they wrote this book from a first line of having to look at several different sources to solve a single clinical problem. The introductory chapters contain sound clinical advice on a general approach to patients with mononeuropathy. Then each nerve is dealt with in turn using multiple sources to solve a single clinical problem. The line drawings of the anatomy are clear, highlighting sites of compression. The line drawings of power testing are less satisfactory. The movement to be tested is well illustrated but the site of the muscle being tested (and hopefully observed) is not shown and for some muscles lies outside the illustration. This is followed by some chapters discussing causes of peripheral nerve injury other than focal lesions, including metabolic and physical factors and tumours. The description of the clinical syndromes is clear and succinct and well referenced throughout. The advice is sensible with a strong emphasis towards conservative management with clear statements as to when more rapid intervention is needed.

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