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*Department of Neurology and Neurological Surgery
Washington University School of Medicine
St. Louis, MO 63110*

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Reply

Slavica K. Katusic, MD, C. Mary Beard, RN, MPH,
W. C. Wiederholt, MD, Erik J. Bergstralh, MS,
and Leonard T. Kurland, MD, DrPH

We thank Dr Landau for bringing to our attention the clinical trial of steroid use in Bell's palsy conducted by May and colleagues [1]. Although we overlooked that study, our review of the article reveals several flaws that leave standing our statement that an appropriate randomized clinical trial is needed.

First, the study group of 51 patients was selected from a larger series of 251 consecutive patients seen by two physicians over a two-year period. The only patients included were those who had 6 months of follow-up. It would seem impossible to know at the time of randomization which patients could be followed for 6 months; therefore, some of the patients who were randomized to treatment may not have returned for follow-up. The authors do not indicate clearly the selection process and which cases were excluded from the study.

Second, and most important, studies with negative results, such as this one, should have a statement regarding the power of the study to detect a meaningful difference or to provide confidence limits for the possible treatment effect, but such information is lacking. If there is incomplete recovery in 40% of Bell's palsy cases, as is suggested by this study, then, with 25 patients per group, the study has less than a 50-50 chance ($\alpha = 0.05$, one-sided test) of detecting a halving of the failure rate to 20% [2].

Third, there was no true placebo group; the control subjects received multivitamins and it is conceivable that such treatment may have benefited some patients.

Thus, we believe that a randomized clinical trial is still needed to test the hypothesis that steroids are effective in the treatment of Bell's palsy.

*Mayo Clinic and Mayo Foundation
Rochester, MN 55905*

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Glossopharyngeal Neuralgia: Successful Treatment with Baclofen

Robert A. Ringel, MD, and E. P. Roy, III, MD

Glossopharyngeal neuralgia, when unresponsive to carbamazepine (CBZ) therapy, has prompted surgical intervention, including intracranial neurotomy, open and percutaneous rhizotomy of the petrous ganglion, and microvascular decompression of the glossopharyngeal nerve [3-5]. The following case description suggests the usefulness of baclofen in the medical management of glossopharyngeal neuralgia paroxysms that are refractory to CBZ therapy.

A 55-year-old woman presented with a six-week history of paroxysmal pharyngeal pain that radiated to the left mandibular angle and neck. The lancinating pain occurred in four to six clusters daily, with several paroxysms per cluster. Severe pain was elicited by swallowing and was associated with a 15-kg weight loss. CBZ (600 mg per day) was tried without benefit.

Examination revealed a fatigued woman experiencing pain on the left side of her neck. Attempts to swallow saliva during the conversation produced several paroxysms of pain. Tactile stimulation of the left posterior pharyngeal wall with a tongue blade consistently elicited painful paroxysms. There was no tenderness of the left tonsillar fossa or neck. Ear, nose, and throat evaluations, including indirect laryngoscopy, showed negative findings. Computed tomographic scan of the head, including the base of the skull, was normal. Skull films did not demonstrate an elongated styloid process. The serum CBZ level was 6.7 $\mu\text{g/ml}$ (4.0-10.0 $\mu\text{g/ml}$) on 600 mg/day.

CBZ doses were first increased, and then baclofen was added. CBZ was increased by 200-mg increments to 1,200 mg/day, without improvement. CBZ was then decreased to 600 mg/day following the onset of ataxia and vomiting. Baclofen was rapidly adjusted to 30 mg/day, followed by a marked decrease in pain intensity after two weeks. The patient essentially became pain-free after the baclofen dose was increased to 40 mg/day. After two months, an attempt to decrease the dose to 30 mg/day resulted in an exacerbation of symptoms. Subsequently, she has been free of pain for six months while taking baclofen, 40 mg/day.

CBZ has provided a limited medical approach to treatment of painful neuralgias [1]. A double-blind study, using baclofen alone or as an adjunct to CBZ, demonstrated a significant reduction in the painful paroxysms of trigeminal neuralgia, and provided an alternative to surgery [2]. Our experience suggests that baclofen may be similarly useful in the treatment of glossopharyngeal neuralgia.

*Department of Neurology
West Virginia University Medical Center
Morgantown, WV 26506*

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Nocturnal Myoclonus, Restless Legs Syndrome, and Abnormal Electrophysiological Findings

P. Martinelli, MD, G. Coccagna, MD,
and E. Lugaresi, MD

In their elegant electrophysiological study, Wechsler and associates [6] found electrophysiological abnormalities consistent with increased excitability of both brainstem and spinal cord reflexes in patients with periodic leg movements of sleep. Previously, we described 5 patients with restless legs syndrome and 1 patient with nocturnal myoclonus [5]. Three patients with restless legs and the patient with nocturnal myoclonus showed an impaired excitability curve for the H reflex, more marked during the night, with a slope similar to those observed in patients with spasticity [2].

In the same patients, the flexion reflex of the biceps femoris muscle [3] and extensor reflex of the soleus muscle [1] failed to show habituation and were followed by long-latency components. Thus, the spasticity-like excitability curves of the H reflex found in our patients confirm the findings of Wechsler and colleagues [6] concerning an increased excitability level of the motor neuron pool of the soleus muscle in periodic leg movements during sleep.

The similarity of electrophysiological data in nocturnal

myoclonus and in restless legs emphasizes the close association between these two syndromes [4].

Neurological Institute of University of Bologna
7, Via U. Foscolo
40123 Bologna, Italy

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Reply

Lawrence R. Wechsler, MD, John Stakes, MD,
B. T. Shahani, MD, and Neil Busis, MD

The electrophysiological findings reported by Dr Martinelli and colleagues in 5 patients with restless leg syndrome and 1 patient with nocturnal myoclonus are most interesting. Their tests differed from those used in our study, emphasizing the need for a battery of electrophysiological tests to define the spectrum of abnormalities that occur in such patients. This work provides additional evidence for a central nervous system disorder in patients with periodic leg movements of sleep, and suggests a similar process may contribute to the pathophysiology of restless leg syndrome.

Department of Neurology
University of Pittsburgh School of Medicine
322 Scaife Hall
Pittsburgh, PA 15261