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 cortical signals to the spinal cord (corticorubrospinal pathway) could be the cause. This could also explain the cause of tremors 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: sutikshanv@yahoo.com

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Lower end of ventriculoperitoneal shunt embedding in liver parenchyma

Sir,

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

A 5-year-old female child had a non-communicating hydrocephalus. A Medtronic moderate pressure ventriculoperitoneal shunt was inserted. After about 15 days of surgery, the patient 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. Ultrason 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 parenchyma and a cystic cavity around the tip of the tube. The patient was given preoperative cover of 3rd generation cephalosporin 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 postoperative 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 authors want to share their experience of this never before reported 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 functions since childhood. The parents also complained of episodic 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 myopathic pattern in all four limbs. Nerve conduction study was
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, first described in 1942, is said to be the most common sex chromosomal aberration (0.9 per 1000). This is often associated with cognitive disorders and increased incidence of behavioral abnormalities. EEG shows spike wave changes. Some cases show reduction in muscle tone and neuromotor developmental delay 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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