



Your Questions Answered

STROKE

Q My father recently had a stroke. What's the best form of therapy to help get him started talking again?



DR. ARGYE BETH HILLIS ADVISES:

A The first step in getting your father talking again is to have him evaluated by a speech-language pathologist who will determine what your father can do on his own and what he will need assistance with.

The speech pathologist will help design a plan to treat his aphasia. The therapy doesn't all have to be done with a speech therapist. If your father is willing and able to work on his own at home, there are computer programs and workbooks that he can use to work on his language skills.

One thing to keep in mind: The most important thing about the therapy is that it should be intense. This means the person should be working on language skills at least two hours a day, five days a week.

There was a fairly large randomized trial that showed that it didn't matter whether the aphasic person worked with a trained family member or a speech therapist—both were effective in improving language skills.

Exercises for people who have trouble speaking after a stroke are designed to help with word retrieval, sentence production, comprehension, reading, or spelling. The idea is to elicit successful language production or comprehension as frequently as possible, by any means. There are a lot of tricks for helping people elicit words with assistance. For example, you might make the initial sound of the word to help them retrieve it. You might teach the person to think of the first letter of the word and then write it down. Sometimes seeing the first letter of the word can help with retrieval of the whole word.

The computer programs work in much the same way. For instance, to prompt for a word, they might show a picture and then the first sound of the word. The cues are gradually withdrawn, to help the person say the word independently.

Argye Beth Hillis, M.D., is professor of neurology and an aphasia expert at Johns Hopkins University School of Medicine.

NEUROPATHY

Q If the cause of my neuropathy can't be found, how does that affect treatment and prognosis?



DR. NORMAN LATOV ADVISES:

A In one-quarter to one-third of patients with neuropathy, no cause can be found. In this case, the neuropathy is called "idiopathic." The translation from the Greek roots means "of its own kind," but one frustrated patient pointed out that the term makes her think of a combination of "idiotic and pathetic."

When a cause for the neuropathy is not known, your physician will direct treatment at alleviating the symptoms. Neuropathic pain, if present, can be treated by any one or a combination of available medications. And physical therapy can help improve or limit any functional impairment. In most instances, idiopathic neuropathy is self-limiting and isn't commonly debilitating.

If significant deterioration does occur, your neurologist may recommend a nerve and muscle biopsy, if one has not already been done. The biopsy could reveal uncommon conditions that might be missed by other tests such as non-systemic vasculitis, amyloidosis, or atypical chronic inflammatory demyelinating polyneuritis (CIDP).

If your doctor suspects that the neuropathy is autoimmune rather than idiopathic, an approach might be to try an immune therapy, such as prednisone (a steroid), plasmapheresis (blood removal and reinfusion after antibodies have been filtered out), or intravenous gammaglobulins (a treatment to quiet the autoimmune response). In the absence of a firm diagnosis, however, treatment with these therapies is controversial and would require the patient's informed consent, with full consideration of the potential risks and benefits, as well as approval by the patient's insurance company.

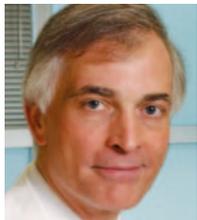
Norman Latov, M.D., Ph.D., is director of the Peripheral Neuropathy Clinical and Research Center at Weill Medical College of Cornell University in New York City.

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DYSTONIA

Q After years of painful symptoms, I've finally been diagnosed with cervical dystonia. What are the latest therapies?



DR. ANTHONY LANG ADVISES:

A Cervical dystonia is a movement disorder that causes muscle spasms in the neck and can produce abnormal posture of the head and neck. The spasms can lead to a pulling of the head in one direction or another. Sometimes the person's head will shake from side to side.

It's not unusual for these movements to be accompanied by pain in the affected muscles. In fact, pain can be the predominant symptom.

Although the problem originates in the brain, the current treatment of choice focuses on the neck muscles themselves.

To quiet the jerking or shaking, neurologists inject a low dose of botulinum toxin (Botox) into the spasming muscle or muscles. The toxin leads to a withering of the nerves that causes the spasming, but eventually the nerve will grow back and another injection will be needed.

The majority of patients can be managed with botulinum toxin alone, although some will also need medication, too. Typically this would be a muscle relaxant, an antispasmodic medication, or an anticholinergic medication.

A small percentage of patients develop antibodies to the toxin and become resistant to it. Management of these patients (or those not helped by botulinum toxin in the first place) has been exceedingly difficult since medications generally are only moderately effective at best. In selected patients, surgery directed at severing the affected nerves has been very helpful. There is a long history of brain operations (functional neurosurgery) for cervical dystonia but this had been largely given up until the recent application of deep brain stimulation to other forms of dystonia.

Deep brain stimulation is a technique in which electrodes are implanted into a part of the brain called the globus pallidus, and very preliminary data suggests this can help both the movements and the pain in patients with cervical dystonia. Low-voltage stimulation appears to shortcircuit the abnormal signals going from the brain to the neck muscles.

Anthony E. Lang, M.D., is director and founder of the Movement Disorders Centre at Toronto Western Hospital.

EPILEPSY

Q Though medication is controlling my daytime seizures, I'm still having them at night. Should I be worried about this?



DR. MARC DICHTER ADVISES:

A This is a very complicated question. As a rule, seizures are more likely to occur during sleep than in wakefulness. For many people, nighttime is the only time when seizures occur. For others, nocturnal seizures are just more frequent than those occurring during the daytime.

We don't really know why there's an increased susceptibility to seizures during sleep. But it's probably related to certain sleep processes that synchronize brain circuits, and this may facilitate seizures.

Most medications prevent seizures from developing and spreading from a part of the brain that may have been injured. The drugs can lessen the intensity and/or frequency of the seizures. While the ultimate goal is to stop the seizures completely, sometimes nocturnal seizures continue.

Whether nocturnal seizures are dangerous depends on the type of seizures and their frequency.

If you are having brief partial seizures only at night, they may not be of great significance. On the other hand, if you are having larger partial seizures or grand mal seizures (generalized tonic-clonic seizures), a delicate balance may need to be struck between trying to eliminate the nocturnal seizures and increasing medications until toxicity appears. If your medications are being used optimally, it may make more sense to tolerate infrequent nocturnal seizures rather than to increase the dosages to levels where you start experiencing unpleasant and potentially dangerous side effects.

But, if you're frequently experiencing more intense or grand mal seizures, your doctor may want to adjust your medications because the seizures could put you at higher risk for brain injury or for a rare, fatal complication called sudden unexpected death in epilepsy patients (SUDEP).

The bottom line is that this is a very complex issue that should be discussed in detail with your doctor.

Marc Dichter, M.D., Ph.D., professor of neurology and pharmacology at the University of Pennsylvania School of Medicine, is co-director of the Penn Epilepsy Center.