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Essential Neurosurgery. Second Edition. Edited by andrew h kaye. (Pp 448 £23.50). Published by Churchill Livingstone, Edinburgh 1996. ISBN 0443053472. The second edition of this basic textbook gives a clear and concise introduction to neurosurgery. It is mainly written by one author with contributions from his neurological and neurosurgical colleagues at the Royal Melbourne Hospital. The text is well written, beginning with an excellent chapter on neurological assessment and examination, and proceeding to covering the whole of neurosurgery in 21 chapters. There are a large number of illustrations with good quality reproduction of imaging. Neurosurgical controversies are well argued with balanced approaches to difficult areas—for example, the treatment of spontaneous intracerebral haematomas. Advances in some treatments such as gene and immunotherapy are well covered, but the sections on other new techniques—for example, endoscopy, image-guidance and interventional radiology are brief.

the surgery and how much to the underlying pathology is difficult to assess. The incidence of postoperative seizures following aneurysm surgery is about 20%, with seizures being most common with middle cerebral artery aneurysms. A similar incidence is reported for convexity meningiomas. Burr hole biopsy has a lower incidence of seizures of 9%. Seizures do not complicate posterior fossa surgery. Postoperative prophylaxis Most studies assessing the value of seizure pro- EPILEPSY AND ITS NEUROSURGICAL ASPECTS phylaxis with antiepileptic therapy have shown a reduction in the incidence of postoperative seizures. Phenytoin is the drug of choice for postoperative seizure prophylaxis. As the incidence of seizures is high during the first postoperative week, patients should receive a preoperative loading dose of phenytoin and then continue on maintenance therapy. If seizures do not occur and the intracranial lesion has been excised, prophylactic treatment with phenytoin is usually discontinued after 6 months. If seizures occur despite adequate phenytoin plasma levels, carbamazepine should be introduced. Tumours and seizures Although the major concern when a patient presents with a seizure is the possibility of a cerebral tumour, tumours are responsible for late-onset epilepsy (as defined by seizures occurring after the age of 25 years) in only about 10% of cases; the incidence is higher in patients presenting with partial seizures. Tumours are an uncommon cause of childhood epilepsy. Seizures are a common presentation in patients presenting with a brain tumour: approximately 50% of patients present with a seizure. There is an inverse relationship between the grade of malignancy of a glioma and the risk of seizure. The incidence of seizures with meningiomas is approximately 50%, 40% with glioblastoma multiforme and 80% with anaplastic astrocytoma. Investigation of seizures and epilepsy Investigation of seizures includes: • history of seizures • general and neurological examination • routine (interictal) EEG • CT scan • MRI • video EEG monitoring. The initial step in investigating a patient presenting following an epileptic seizure is to obtain a full history from the patient and a witness account of the event. A history of febrile convul- 273 sions of infancy in a patient presenting with complex partial seizures of temporal lobe origin suggests the diagnosis of MTS. A history of a significant head injury may suggest posttraumatic epilepsy and a strong family history of epilepsy suggests a primary generalized epilepsy. The EEG is non-invasive and relatively inexpensive and is performed as an outpatient. The technique involves the recording of electrical activity from the surface of the brain by the use of scalp electrodes. The electrodes are placed at multiple sites over the scalp, allowing recordings to be made from multiple anatomical sites at one time. These patterns of recording sites are known as montages. The normal adult EEG has a background rhythm of frequency of 8–13 Hz, known as alpha rhythm. Fast activity of greater than 13 Hz is known as beta rhythm and may be seen bifrontally or with drugs such as barbiturates and benzodiazepines. Slow activity is categorized as theta rhythm of 4–8 Hz and delta rhythm of less than 4 Hz (Fig. 21.1). The normal adult resting EEG contains only a minimal amount of theta rhythm and no delta activity. Excess slow wave activity during the resting tracing is abnormal and may be generalized, such as in an encephalopathy, or focal, as with a structural lesion such as a glioma or abscess. The routine EEG comprises a resting tracing and two provocative tests, hyperventilation and photic stimulation. These provocative tests may induce epileptic activity and hyperventilation may accentuate a focal abnormality. The EEG is of particular value in showing: • focal abnormalities suggesting an underlying focal structural lesion and suggesting the seizure is partial in type Alpha rhythm (8-13 Hz - cycles/sec) Beta rhythm (>13 Hz) Theta rhythm (4 - 8 Hz) Delta rhythm (E-Book Information Year: 2,005 Edition: 3 Pages: 309 Pages In File: 309 Language: English Topic: 165 Identifier: 1-4051-1641-2 Org File Size: 6,634,148 Extension: pdf Tags: Медицинские дисциплины Неврология и нейрохирургия

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