chogenic is very difficult. We agree with Dr. Sudo, stated in our manuscript, that additional documentation of the attacks with PET or SPECT studies would have been helpful. However, these studies were not possible in our center at the time these patients were observed. With regards to the EEG recordings, however, all four cases were recorded with both scalp and sphenoidal electrodes.

In our cases, the diagnosis of psychogenic basilar migraine rested principally upon four factors: failure to respond to aggressive antimigraine (or antiepilepsy) medication in all four patients; extensive diagnostic studies, including MRI, MRA, cerebral angiography, and interictal PET scans, failed to document any abnormalities; ability to provoke typical symptoms with suggestion and provocation in all four patients; and dramatic improvement in two patients with psychogenic symptoms.

However, their differential in clinical practice can be quite difficult despite psychiatric consultation and follow-up. Nonepileptic psychogenic seizures now represent approximately 20% of our inpatient unit and have been identified in over 30% of seizure patients in a general neurology setting using provocative testing with suggestion. Regardless of the exact percentages, nonepileptic psychogenic seizures are now commonly recognized. Among patients with headache that is chronic and responds poorly to aggressive medication trials, it is likely that a surprising percentage have psychogenic factors contributing to, or largely accounting for, their symptoms. The challenge will be to accurately identify such patients.

Finally, the issue of distinguishing conversion disorder from malingering is raised. We agree that these disorders are quite distinct. However, their differential in clinical practice can be quite difficult despite psychiatric consultation and follow-up.

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References

Corrections
In “Unilateral spatial neglect recovery after sequential strokes” by Vuilleumier et al., which appeared in the January issue (Neurology 1996;46:184–189), a sentence appeared incorrectly in the second paragraph of the Discussion section on page 187. The sentence reads “The cortical area in the dorsal angular gyrus, constituting the ventral lip of the intraparietal sulcus, corresponds precisely to the architectonic pneumoencephalographic (PEG) area, which Eidelberg and Galaburda found to have a rightward size lateralization in human brains.” It should have read: “The cortical area in the dorsal angular gyrus, constituting the ventral lip of the intraparietal sulcus, corresponds precisely to the PEG area, which Eidelberg and Galaburda found to have a rightward size lateralization in human brains.”

In “Delayed emergence of a parkinsonian disorder in 38% of 29 older men initially diagnosed with idiopathic rapid eye movement sleep behavior disorder” by Schenk et al., which appeared in the February issue (Neurology 1996;46:388–393), a sentence appeared incorrectly in the first paragraph of the Methods section. It read: “In a series of 96 RBD patients (mean age, 52 yr; range, 9–81 yr), 33 men who had idiopathic RBD at the time of initial diagnosis; 88% of these men were available for follow-up.” It should have read: “In a series of 96 RBD patients (mean age, 52 yr; range, 9–81 yr), 33 men ≥ 50 years who had idiopathic RBD at the time of initial diagnosis; 88% of these men were available for follow-up.”

In “Brain choline-containing compounds are elevated in HIV-positive patients before the onset of AIDS dementia complex: A proton magnetic resonance spectroscopic study” by Tracey et al., which appeared in the March issue (Neurology 1996;46:783–788), a second corresponding author’s address was omitted. The additional corresponding author is: Dr. B.A. Navia, Department of Neurology, Massachusetts General Hospital, Boston, MA 02118.