attributable to detrusor sphincter dyssynergia.[3] In fact, our results showed that although urinary symptoms were slightly more frequent in men, incidence was not influenced by age or such clinical characteristics as the subtype of motor neuron disease.[6] Furthermore, an association was found between presence of urinary symptoms and poorer prognosis.[6] Our findings contradict the idea, widespread among both patients and healthcare professionals, that urinary symptoms are rare in ALS and secondary to loss of mobility.[7] Screening for filling and voiding symptoms and urinary incontinence with validated questionnaires is essential in patients with ALS due to the negative impact that these potentially treatable problems may have on patient quality of life.[3]

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Conflicts of interest

None.

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Primary central nervous system lymphoma mimicking cerebellopontine angle lesion☆

Linfoma primario del sistema nervioso central aparentando lesión del ángulo pontocerebeloso

Dear Editor:

It was with great interest that we read the article by Berrocal-Izquierdo et al.,[1] describing the case of a patient with primary central nervous system lymphoma (PCNSL) associated with symptoms of a left cerebellopontine angle lesion. According to the authors, prior to their report, 16 cases had previously been reported of PCNSL mimicking cerebellopontine angle masses.

In 1994, our research group reported the clinical-pathological case of a patient with PCNSL presenting as a left cerebellopontine angle lesion; at that time, 7 similar cases had been described.[2] A literature search on PubMed (''cerebellopontine angle lymphoma,'' on 29 November 2018) yielded 52 results; although not all references describe patients with PCNSL, these results do suggest that the association between cerebellopontine angle lesions and PCNSL may not be as rare as one may think.

Our patient was a 39-year-old woman with one-year history of occipital headache showing poor response to analgesics.[2] She was admitted due to exacerbation of headache, with vomiting, otalgia, hearing loss, and left-sided facial paraesthesia. A head CT scan revealed a

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contrast-enhancing tumour in the left cerebellopontine angle, obliteration and post-contrast enhancement of the basal cisterns, and ventricular dilation. Four CSF analyses revealed sterile lymphocytic pleocytosis, low glucose levels, and elevated adenosine deaminase levels; CSF cytology detected no malignant cells. The patient received tuberculostatic drugs and corticosteroids due to suspected tuberculous meningitis, but died 2 months later. The autopsy revealed PCNSL with leptomeningeal and perivascular infiltration, as well as microscopic subpial infiltration. In line with the macroscopic findings, subpial infiltration was more marked on the left side, affecting the pons and the middle cerebellar peduncle (see figures 2a and 2b in Berciano et al.[2]).

PCNSL is a subtype of non-Hodgkin lymphoma that exclusively affects the brain, eyes, spinal cord, and leptomeninges, without systemic involvement.[3] Symptoms depend on lesion topography, with most patients presenting symptoms including cognitive impairment, focal neurological signs, and symptoms of intracranial hypertension, developing over the course of several weeks or months. Around 20% of patients display concurrent leptomeningeal infiltration, which is frequently subclinical and only detectable with CSF analysis. In our case, 4 CSF analyses were insufficient to detect malignant cells; in fact, 3 analyses showed elevated adenosine deaminase levels, which led to suspicion of tuberculous meningitis.[4]

In our patient, the histology study revealed mild, extensive perivascular infiltration of the Virchow-Robin spaces with subpial infiltration, occasionally extending to cover large areas of the brain parenchyma, visible on a macroscopic scale. Any lesion that reaches a critical size, including cerebellopontine angle lesions, may cause focal neurological symptoms.

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Response to ''Spontaneous acute epidural haematoma of the cervical spine with an atypical onset resembling ictal symptom''☆

Respuesta a «Hematoma epidural agudo cervical espontáneo de inicio atípico simulando cuadro ictal»

Dear Editor:

We read with great interest the letter to the editor by Arévalo et al.[1] entitled ''Spontaneous acute epidural haematoma of the cervical spine with an atypical onset resembling ictal symptom.'' We would like to thank the authors for the valuable clarifications on the management of these patients. Most of the conclusions and information on this type of disease are from a small number of case reports with an inherent selection bias, or small series that lack detailed statistical analysis. However, we would like to clarify some points based on our experience and on the only Spanish multicentre study, conducted by members of our working group, which included 29 patients with surgically treated spontaneous epidural spinal haematoma.[2]

We agree with Arévalo et al.[1] that treatment of this type of lesions is essentially surgical. Furthermore, in patients presenting spontaneous improvement or whose health condition contraindicates surgery, a conservative approach should be adopted. Spontaneous improvement is more frequent than we may expect[3]; in our series, we excluded 2 patients who presented excellent progression, eventually recovering, despite not having received surgical treatment. The usefulness of corticosteroids in patients ineligible for surgical treatment has not been clearly demonstrated in the case of spinal haematoma[4]; all the available conclusions and recommendations are from the NACIS multicentre study.[5]

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