



Neuroimaging of first-ever seizure: Contribution of MRI if CT is normal

Nitin K. Sethi, MD: I read with interest the study by Ho et al.¹ on the contribution of MRI scan in the diagnostic management of first-ever seizure. Standard MRI may fail to detect potential focal epileptogenic lesions and thus MRI using a dedicated epilepsy protocol such as that performed at epilepsy surgery centers is recommended nowadays.² That it is superior to CT scan to detect potential epileptogenic lesions is well-established and the Ho et al. study attests to this. However, one should not forget a few situations such as a calcified neurocysticercosis lesion where a CT scan may have superior sensitivity for lesion detection.³ When a potential epileptogenic lesion is detected on MRI, whether it is the culprit lesion or an incidental finding needs to be determined, for patients can harbor dual pathologies such as mesial temporal sclerosis and focal cortical dysplasia.⁴ With rapid advances occurring in MRI technology, we can soon expect to have higher resolution MRI scans with more sensitive imaging protocols. The Ho et al. study helps reinforce the importance of EEG in the “neuroimaging” of first-ever seizure. Concordance of EEG and MRI findings is paramount for establishing the true epileptogenic potential of the lesion.

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Disclosures: N. Sethi serves as Associate Editor for *The Eastern Journal of Medicine*.

Authors Respond: Kevin Ho, MBBS, Nicholas Lawn, FRACP, Michael Bynevelt, FRANZCR, Judy Lee, BA (Nsg), John Dunne, FRACP: We thank Dr. Sethi for his comments.

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Postmarketing adverse drug reactions: A duty to report?

Khichar Shubhakaran, MBBS, MD, Rekha Jakur Khichar: We read with interest the article by Klein and Bourdette,¹ which highlights the ethical issues pertaining to adverse drug reactions. We agree that adverse reactions should be communicated to the manufacturer of the drug in question. However, sometimes the manufacturer will defer blame to an aspect of

drug dispensing or concurrent drug use, so this is only the first avenue of recourse. It is also important to report adverse effects in a reputable and widely distributed medical journal. Unfortunately, case reports are being given less and less import in many of these journals. Case reports are seen as not novel, simply confirmative, and less interesting to readers. Let us not forget that our knowledge of neurology is fashioned case by case.

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Authors Respond: Eran Klein, MD, PhD, Dennis Bourdette, MD: Drs. Shubhakaran and Khichar astutely identify 2 important tensions in the quest to improve drug safety: 1) balancing commercial and public interest at the point of scientific translation to clinical care and 2) balancing time-honored ways of educating and improving clinical care, including reliance on case reports, with new tools made possible by the collection of “big data” and electronic communication. We agree with the commentators that attributing side effect causation to a medication is a challenging affair and one that relies on contextual interpretation, which if left solely in the hands of manufacturers with vested commercial interests would raise concern. It is preferable for clinicians to report adverse events directly to the Food and Drug Administration (FDA) via Medwatch as it removes the relevant pharmaceutical company from the process. However, reporting directly to the manufacturer is a reasonable alternative as FDA regulations on manufacturer reporting of adverse events standardize what manufacturers must disclose, significantly reducing manufacturer reporting discretion. As students of medical history, we find the receding prominence of the traditional clinical case regrettable, but as educators we see also an opportunity for the emergence of new forms of the case report, perhaps ones that are more timely, standardized, and useful for the practicing clinician.

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Disclosures: E. Klein has received honoraria for speaking at AAN meetings, serves on a Data Safety Monitoring Board for the NIMH, receives publishing royalties for *Story of Bioethics* (Georgetown University Press, 2003), and received a geriatric neurology fellowship from the US Department of Veterans Affairs. D. Bourdette has received educational grants and speaker honoraria from Teva Neuroscience, Biogen Idec, Novartis, and EMD Serono, Inc.; serves as an Associate Editor for *Journal of Medicinal Medicine* and *Autoimmune Diseases*, Section Editor for *Current Neurology and Neuroscience Reports*, and on the editorial board for *Neurology*[®]; has a patent pending for the treatment of MS with cyclic peptide derivatives of cyclosporine; has served as a consultant to Elan Corporation; is on the Speakers' Bureau for Biogen Idec; and has received research grants from the NIH/NINDS (1R01NS057433), the US Department of Veterans Affairs, and the National Multiple Sclerosis Society.

1. Klein E, Bourdette D. Postmarketing adverse drug reactions: a duty to report? *Neurol Clin Pract* 2013; 3:288–294.

Standard strategies for diagnosis and treatment of patients with newly diagnosed Parkinson disease

Nitin K. Sethi, MD: As always, I found the Practice Across Borders article on diagnosis and treatment of patients with newly diagnosed Parkinson disease (PD) a fascinating read, and found myself asking: Why this difference in practice across borders?¹ Like many diseases in neurology, the diagnosis of idiopathic PD remains a clinical one and in spite of the MRIs, DaTscans, and I¹²³-metaiodobenzylguanidine myocardial scintigraphy scans available today,

this has remained unchanged from the days of James Parkinson. Why, then, in some countries is a patient more likely to get one of these radiologic tests and in another not? Is it just because the test is available that I am more likely to order it in a patient with atypical PD if I am practicing in the United States vs, say, India? Do neurologists in the United States practice better neurology than neurologists in India when it comes to PD? Is the care of a patient with PD better in France than, say, Brazil? I found myself asking all these questions and agree with Dr. Barbano that only large-scale high-quality standardized outcome data from different countries can help answer these questions.

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Disclosures: N. Sethi serves as Associate Editor for *The Eastern Journal of Medicine*.

Author Responds: Richard L. Barbano, MD, PhD, FAAN: As Dr. Sethi points out, the use of ancillary testing in the diagnosis of PD, and the treatment of PD, varies from country to country. The availability of particular tests and medications almost certainly plays a role in this variability. Much progress has been made and despite the variability of choices, many treatments are helpful. One of the challenges facing neurologists today, however, is not just finding which approaches work, but which work best; which approaches not just improve symptoms, but which improve outcomes as measured in quality of life for the longest duration. The technology to analyze such data already exists. The challenge will be to organize a global effort to collect it.

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1. Barbano RL. Standard strategies for diagnosis and treatment of patients with newly diagnosed Parkinson disease. *Neurol Clin Pract* 2013;3:475–476.

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Generic substitution of antiepileptic drugs: What's a clinician to do?

In the article “Generic substitution of antiepileptic drugs: What's a clinician to do?” by Khichar Shubhakaran and Rekha Jakhar Khichar (*Neurol Clin Pract* 2013;3:457), there is an error in the second author's name, which should read “Rekha Jakhar Khichar.” The editorial staff regrets the error.

Multiple sclerosis: Five new things

In the article “Multiple sclerosis: Five new things” by JA Nicholas et al. (*Neurol Clin Pract* 2013;3:404–412), there is an error on page 406. The first full sentence should read “There was a 55% reduction in annualized relapse rate (ARR), the study's primary outcome...” The publisher regrets the error.

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