

The Nerve! Readers Speak

Reader Response: Practice Current: How do you treat neuromyelitis optica?

Jagannadha Avasarala, Greenville, SC

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A few lingering questions on this topic.¹

1. I find it strange that Ocrevus, a CD20 blocker, is akin to Rituxan but not even on the map for treatment of neuromyelitis optica spectrum disorder (NMOSD), although Rituxan has been extensively used for this disease.
2. What is double-negative (Ab) NMOSD? Does it exist?
3. One hopes that there are better guidelines for monitoring CD19 cell counts (how frequent, endpoints, pitfalls, variations between end-stage disease and early-onset disease, if any).
4. Pregnancy vs disease-modifying drugs in NMOSD is characterized by paucity of data. We need better data. Also, data collected will hopefully be openly shared among researchers so that there are many minds working on the same topic instead of a select few.

1. Ganesh A. Practice Current: how do you treat neuromyelitis optica? *Neurol Clin Pract* 2017;7:170–178.

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Author Response: Practice Current: How do you treat neuromyelitis optica?

Aravind Ganesh, Calgary, Canada

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I thank Dr. Avasarala for responding to the Practice Current on neuromyelitis optica,¹ and for highlighting some key unresolved questions in this field.

Perhaps the use of ocrelizumab in neuromyelitis optica spectrum disorder (NMOSD) might increase following its approval in 2017 for the treatment of relapsing-remitting and primary progressive multiple sclerosis; our practice survey preceded or overlapped with this, and it would be interesting to repeat the assessment a few years down the road to see if preferences have changed in response to new evidence or trials. Concurrently, guidelines for monitoring CD19/20 cell counts in patients on B-cell-targeting therapies will likely evolve, and I was pleased to come across a recent article by Dr. Avasarala² on this topic, suggesting that CD19 cell populations may be used as a surrogate for CD20 cells on a monthly basis to guide ocrelizumab redosing parameters.

The question of double-seronegative NMOSD is one that we could discuss only briefly in the main body of the article. However, we were able to delve into this topic in some more detail with the experts we interviewed, particularly Dr. Maria Isabel Leite (Oxford), who agreed that this is a difficult diagnosis to make, and one that she basically considers a diagnosis of exclusion, ruling out other competing differential diagnoses. If a seronegative patient has a relapse, the practice favors reviewing the diagnosis, including retesting for aquaporin-4 and MOG antibodies, and if no better etiologic diagnosis is found, then chronic immunosuppressive

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treatments are considered. I agree that this remains a gray area meriting further systematic study.

I also agree that high-quality data collection and sharing on pregnancies in NMOSD (and disease-modifying drugs in this setting) will be helpful. Indeed, a recent international cohort study found that pregnancy after NMOSD onset is an independent risk factor for miscarriage—particularly if pregnancies were conceived at times of high disease activity—further highlighting the importance of this topic.³

1. Ganesh A. Practice current: how do you treat neuromyelitis optica? *Neurol Clin Pract* 2017;7:170–178.
2. Avasarala J. Anti-CD20 cell therapies in multiple sclerosis: a fixed dosing schedule for ocrelizumab is overkill. *Drug Target Insights* 2017; 11:1177392817737515.
3. Nour MM, Nakashima I, Coutinho E, et al. Pregnancy outcomes in aquaporin-4-positive neuromyelitis optica spectrum disorder. *Neurology* 2016;86:79–87.

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Reader Response: Uncertainties from a worldwide survey on antiepileptic drug withdrawal after seizure remission

Nitin K. Sethi, New York, NY

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I read with interest the results of the Bartolini et al.¹ worldwide survey on antiepileptic drug (AED) withdrawal after seizure remission. As the authors state, the survey results highlight the pressing need for well-designed studies exploring these issues and the development of standardized guidelines that can guide decision-making when physicians are confronted with the issue of AED withdrawal after seizure remission. In the end, though, every patient is an n of 1 and AED withdrawal decision has to be individualized taking into consideration intrinsic patient factors (type of epilepsy, natural history of that epilepsy/epilepsy syndrome, level of seizure control, seizure type [focal vs generalized], presence vs absence of structural epileptogenic lesion on MRI, presence vs absence of interictal epileptiform discharges on EEG, driving status, socioeconomic status including ability to afford medications) and extrinsic factors (ease of access to health care and experience of treating neurologist/epileptologist). One size does not fit all when considering AED withdrawal after seizure remission.

1. Bartolini L, Majidi S, Koubeissi MZ. Uncertainties from a worldwide survey on antiepileptic drug withdrawal after seizure remission. *Neurol Clin Pract* 2018;8:108–115.

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Author Response: Uncertainties from a worldwide survey on antiepileptic drug withdrawal after seizure remission

Luca Bartolini, Bethesda, MD

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We thank Dr. Sethi for his interest in our article¹ and thoughtful comments. We agree that a one-size-fits-all approach to antiepileptic drug (AED) discontinuation would not make sense; as we stated in the Introduction, ultimately this remains an individualized decision. Nevertheless, there are several clinical scenarios that may potentially represent a rather homogeneous population of patients, for example those with juvenile myoclonic epilepsy or those who underwent a successful uncomplicated temporal lobectomy (with all the caveats

related to driving status and access to care that were eloquently detailed by Dr. Sethi), who could be studied with an appropriate model for prediction of seizure recurrence after AED discontinuation at different time points. This model could potentially represent a useful clinical tool to be utilized in conjunction with several other clinical, personal, and socioeconomic factors when making an individualized decision about AED withdrawal.

1. Bartolini L, Majidi S, Koubeissi MZ. Uncertainties from a worldwide survey on antiepileptic drug withdrawal after seizure remission. *Neurol Clin Pract* 2018;8:108–115.

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CORRECTIONS

A practical approach to detection and treatment of depression in Parkinson disease and dementia

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In the review “A practical approach to detection and treatment of depression in Parkinson disease and dementia” by Goodarzi and Ismail,¹ there are several errors. The sixth sentence of the introduction should clarify, “Even when diagnosed with depression, just 20% of patients with PD and 18% of those in assisted living—where there is a 55% prevalence of dementia—receive therapy.”

The eighth sentence of the introduction should have cited references 2 and 3 in addition to references 11 and 12. In the “Treatment” subsection, reference 46 should have been cited rather than reference 30; similarly, reference 46 should replace reference 30 in lines 2, 13, 43, and 45 on page 130, and line 5 on page 132. The sixth sentence under subsection “Overall approach” should cite only reference 33. The authors regret the errors.

Reference

1. Goodarzi Z, Ismail Z. A practical approach to detection and treatment of depression in Parkinson disease and dementia. *Neurol Clin Pract* 2017;7:128–140.

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What predicts falls in Parkinson disease? Observations from the Parkinson’s Foundation Registry

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In the research article “What predicts falls in Parkinson disease? Observations from the Parkinson’s Foundation Registry” by Parashos et al.,¹ there was an error in the figure title, published online on May 21, 2018, which should have read “Study group sample” rather than “Suggested algorithm to evaluate camptocormia based on clinical presentation.” The figure title was corrected online on Tuesday, June 12. The publisher regrets the error.

Reference

1. Parashos SA, Bloem BR, Browner NM, et al. What predicts falls in Parkinson disease? Observations from the Parkinson’s Foundation Registry. *Neurol Clin Pract* 2018;8:214–222.

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