Anti-thyroid antibodies in temporal lobe epilepsy—to check or not to check?

Keywords:
Temporal lobe epilepsy
Autoimmune disorder
Steroids

Dear Editor,

I read with interest Miro et al.’s study on detecting anti-thyroid antibodies (aTR-ab) in middle aged women with pharmacoresistant late onset temporal lobe epilepsy (TLE) [1]. The author’s advice testing aTR-ab in late onset TLE patients of unknown etiology and treatment with corticosteroids if antibodies are detected. The detection of autoantibodies increases with age. Many a times the titers are low and unclear whether the mere presence of these autoantibodies is indicative of an active disease process warranting immunosuppressive and immunomodulatory therapies. One should consider screening a TLE patient for aTR-ab if onset of TLE is late in life, seizures are medically refractory, faciobrachial dystonic seizures are documented, a personal or family history of autoimmune disease and cutaneous or end organ stigmata of autoimmune disease are present. Testing all late onset refractory TLE patients for aTR-ab risks a high rate of false positives and erroneous treatment with steroids with potential serious side-effects.

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Reference


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Spinal tuberculosis
Pott’s disease
Abscess

Dear Editor,

We have read with great interest the published article by Zou et al. entitled “Treatment of thoracic or lumbar spinal tuberculosis complicated by resultant lisshtes at the involved segment” [1]. At this paper, the authors said “Generally administered in pure spinal tuberculosis without lisshtes, adjuvant antituberculous chemotherapy is essential for improving patient outcomes,” and “Surgery is generally indicated in Pott’s disease in cases of neurologic compromise, painful vertebral lesions, progressive cold abscesses, kyphosis, and therapeutically refractory disease” in discussion section [1].

However, this good manuscript related to lisshtes with spinal tuberculosis, we think that some more points should be discussed on therapy planning.

Some scientists reported paradoxal responses are defined as worsening of existing symptoms or the appearance of new lesions in patients who initially responded well to antituberculous therapy [2,3].

If spinal lesion is limited in the vertebrae and if there are not any complications, triple-drug anti-tuberculous chemotherapy can play a main role to treat tuberculosis [4]. However, with proper indications, surgical procedures are superior in the prevention of neurological deterioration, maintenance of stability and early recovery [5,6].
Oguz et al. [7] reported total 76 cases with spinal tuberculosis have excellent recovery develops without any neurological deterioration. As a result, they developed an effective classification system named GATA.

This classification system is based on seven clinical and radiological criteria (abscess formation, vertebral collapse, disc degeneration, sagittal index, kyphosis, instability and neurological problems). At this system, spinal tuberculosis is divided into three types (Type I A/B, Type II and Type III) by using as this criteria and it also recommends specific therapeutic techniques for each type.

They emphasized if there is a cold abscess, only antibiotic- analgesic therapy cannot prevent the extensive destruction of vertebral bone and disc material [7-9]. After cold abscess and two-level disc degeneration, immediate drainage along with medical therapy can protect the patient from vertebral collapse [7].

We believe that this classification system should be considered as a practical guide for spinal tuberculosis treatment planning in all countries.

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Reply to editorial – Neurophobia: A global and under-recognized phenomenon

We thank McGee and colleagues for their interesting editorial commentary [1] on our paper [2]. We wish to clarify some of the highlighted issues to help advance discussion of this important topic.

Our study included only general practitioner (GP) trainees during their postgraduate training; substantive GPs were not included. An evaluation from GP trainees in their second and third year of specialist training facilitated an up-to-date appraisal of their neurology training by examining the primary and secondary care components of their neurology education. As postgraduate training offers an opportunity to compensate for any fear of the neural sciences, we specifically studied GP trainees. We targeted this group of doctors as educational interventions at early stages of a career may enhance long-term motivation. In a recent study Danish GPs have highlighted the importance of motivation (and therefore interest) to promote continuous professional development and self-directed learning [3].

McGee and colleagues [1] suggest that we barely scraped the surface of the wealth of information, which could be obtained from GP trainees. We have however explored some of the issues in further detail in a focus group study [4]. We then applied triangulation to our mixed methods approach (questionnaire and focus group) to look for emerging themes [4]. This is increasingly acknowledged as an important way of identifying robust findings. Partial or full agreement for improving neurology teaching was identified in areas such as direct communication with a neurologist, more teaching for postgraduate GP trainees and a desire for experiential learning and formative feedback. We believe these are robust findings, which along with our recently published systematic review of educational interventions in neurology [5] represent the beginning of an evidence base “to improve teaching of the various components of neurology in the future”. Our study population called for emphasis on structured, yet simplified education in the area of neurology. In the UK and Ireland neurologists have only been based in district general hospitals within the last 15 years; indeed one of the authors of our paper was the first neurologist appointed in a general hospital in Northern Ireland (in 2003). Most GP training involves 50% district general hospital training and 50% primary care in the UK and Ireland. Even in 2014 neurologists are rarely involved in postgraduate neurology training for GP trainees. This prevents trainees from “assessing different effective instructional approaches” in neurology. Our study is the first published evidence that GP trainees desire experiential learning in neurology. Future research should not be just a summary of trainees’ reactions to a teaching experience, but rather an opportunity to achieve increasingly robust outcomes such as the Kirkpatrick levels of professional development [6] or fulfillment of Guskey’s five critical levels of professional development [7]: participant reaction; participant learning; organization support and change; participant use of new knowledge and skills; and learning outcomes.

McGee and colleagues [1] suggested that other survey questions may have better addressed the presence of neurophobia or the “fear of neural sciences due to an inability to apply knowledge of neurology to clinical situations”. They also expressed concern that response bias may have affected our results. Although our emailed information sheet for the survey entitled Deficits and potential in postgraduate neurology education for GP trainees – a questionnaire study may have risked response bias, a systematic review of questionnaire responses from the questions used by Schon et al. [8] has shown the global nature of neurophobia [9]. We used the questionnaire designed by Schon et al. [8] not only because these survey questions have been repeatedly used