May 8 Highlights

Chlamydia and MS: Pro and con
Yao et al. (p. 1168) previously reported that PCR detected the presence of *Chlamydia pneumoniae* in CSF from patients with MS. Here they report that antibodies reactive to *C pneumoniae* were identified in the CSF of 16 of 17 patients with MS and 2 of 14 controls. Oligoclonal bands were also absorbed by *C pneumoniae* antigens, but not other antigens such as measles, in 14 of 17 patients with MS. As an interesting sidelight, oligoclonal bands were absorbed by measles, and not *C pneumoniae*, in 3/3 patients with subacute sclerosing panencephalitis. ◆ Pro and con editorials consider this controversial article. Gaydos (p. 1126) provides counterarguments on the role of chlamydia in MS. She notes that up to 70% of adults have antibodies to chlamydia and that chlamydia has been postulated to play a role in many diseases including atherosclerosis. Her own laboratory failed to confirm that PCR could demonstrate the presence of chlamydia antigens in the CSF of patients with MS. ◆ Jacobson and Cross (p. 1128) review the evidence for an environmental (infectious) as opposed to a genetic cause of MS and the evidence for and against the association of chlamydia with MS. ◆ The concluding Commentary (p. 1130) notes that a clinical trial using the antibiotics rifampin and azithromycin will consider whether this treatment of chlamydia is of benefit to patients with MS.

Dementia: Diagnosis. Early detection. Treatment.
AAN practice parameters on dementia provide consensus recommendations on these major clinical issues. Petersen et al. (p. 1133) address whether screening for dementia is indicated in the elderly. Those with mild cognitive impairment have memory loss and are at high risk for developing dementia and should be followed. The Mini-Mental State Examination and neuropsychologic testing can be useful in diagnosing and following these persons. ◆ Knopman et al. (p. 1143) note that AD and Creutzfeldt–Jakob disease can now be diagnosed reliably using current criteria. Clinical diagnosis criteria for dementia with Lewy bodies, frontotemporal dementia, and vascular dementias are useful but imperfect. Initial evaluation of dementia should include noncontrast CT or MRI and screening for depression, B_{12} deficiency, and hypothyroidism. Use of genetic markers in diagnosis is not recommended. ◆ Doody et al. (p. 1154) review published outcome data on AD treatments—drugs for cognitive/noncognitive symptoms, caregiver education, and other interventions for patients/caregivers. They conclude that cholinesterase inhibitors have a small benefit; vitamin E delays worsening; antipsychotics are indicated if environmental manipulation does not control agitation/psychosis; and antidepressants, especially selective serotonin reuptake inhibitor, may help patients with depression and dementia. They also review the many nonpharmacologic strategies, some with established benefits, for patients/caregivers such as measures to control incontinence and to maintain function. ◆ In the accompanying editorial, Hogan and McKeith (p. 1131) applaud the success of the monumental tasks accomplished and pose several of the awkward questions that these guidelines do not answer.

Lamotrigine (LTG) versus carbamazepine (CBZ): Effect on cognition and behavior
Meador et al. (p. 1177) compared the effects of LTG versus CBZ in 25 healthy adults treated for 10 weeks with each drug. Performance/behavior was better with LTG than CBZ in many measures including cognitive speed, memory, mood, and sedation.

Vitamin B_{12} and folate and Alzheimer's disease
Wang et al. (p. 1188) measured B_{12} and folate levels and then followed 370 nondemented adults age 75 or older for 3 years. Subjects with low B_{12} or folate levels had twice the risk of developing AD. Monitoring levels of the vitamins may be important for prevention of AD.

Juvenile neuronal ceroid lipofuscinosis (JNCL): L-dopa treatment
Åberg et al. (p. 1236) treated 10 patients with JCNL with L-dopa and 6 with selegiline, and followed 5 as a control group. Parkinsonism signs of JNCL improved only in those patients given L-dopa. Symptoms in untreated patients worsened, as did those in patients given selegiline.

A new formulation of L-dopa: Dual-release
Descombes et al. (p. 1239) compared dual-release with conventional L-dopa; both were combined (with a catechol-*O*-methyltransferase inhibitor) in 16 patients with PD with severe motor fluctuations. The dual-release formulation had a much more rapid effect but a similar duration of action as the conventional treatment.

