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### LONGITUDINAL ASSESSMENT OF OXALIPLATIN-INDUCED NEUROPATHY

**Susanna B. Park, Martin Koltzenburg, London, UK:**

The small sample size may have contributed to the finding of Burakgazi et al.<sup>1</sup> that oxaliplatin produces only mild axonal loss yet others have identified significant axonal loss (greater than 50% amplitude reduction).<sup>2</sup> It is possible that the inclusion of patients with baseline neuropathic symptoms (TNS score  $\geq 4$ ) led to a floor effect with respect to changes in sensory amplitudes and nerve function following oxaliplatin.

It was also interesting that reductions in intra-epidermal nerve fiber density (IENFD) were reported. These are typically utilized to examine small fiber neuropathy.<sup>3</sup> Given the prominent large fiber dysfunction identified in oxaliplatin-treated patients by clinical and neurophysiologic assessments, the finding of small fiber loss is unexpected. The IENFD changes may be too small to be clinically observable through quantitative sensory testing,<sup>4</sup> but may be interesting in terms of the pathophysiologic basis for the development of neuropathy. As such, it is important to replicate this finding in a larger sample.

Finally, the impact of long-term nerve damage remains critical, particularly in the adjuvant setting. These results are similar to previous studies where oxaliplatin produced a long-lasting neuropathy,<sup>2,5</sup> in contrast to the previously held view of reversibility within 6 months.

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### NORMAL PRESSURE HYDROCEPHALUS: HOW OFTEN DOES THE DIAGNOSIS HOLD WATER?

**Richard B. Rosenbaum, Portland, OR:** This article<sup>1</sup> and the accompanying podcast were excellent. Can the authors clarify how soon after the high volume lumbar puncture the patient is examined and how long the effect lasts? For example, is test sensitivity lost if the examination is done 1 hour after the lumbar puncture?

**Author Response: Bryan T. Klassen, Rochester, MN:**

At our institution, the patients are evaluated with videotaped gait examinations immediately before and shortly after (~30 minutes) the high volume lumbar puncture. They are generally seen the following day by the physician who elicits the patient/family's impression of results, views the videos, and repeats the examination. The decision to proceed with surgery was based upon a clearly favorable response to the lumbar puncture, whether or not this was sustained the following day. We did not have sufficient data to explore the question of how the test's sensitivity changes over time.

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*Author disclosures are available upon request (journal@neurology.org).*

# Neurology®

## Longitudinal assessment of oxaliplatin-induced neuropathy

Susanna B. Park and Martin Koltzenburg

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clear analysis of the successes and challenges facing the UCNS. It seems that the ship has sailed in terms of neurology trainees pursuing subspecialization and super subspecialization and this is a trend that will likely continue. This trend has its disadvantages, especially in academic neurology departments. Academic neurology departments are becoming more similar to internal medicine departments with various subspecialty divisions. But what about “general” neurology? I suspect that academic general neurologists are a dying breed, and this problem will only become more acute over time as the current “master clinicians” retire. This will lead to a reduction in general neurology teaching to medical students and residents, as well as a potential loss of clinical revenue to academic departments when the only general neurologists willing to see “undifferentiated” patients are in the community. General neurology is a “specialty” in its own right, yet if residency training in neurology simply becomes a means to an end of subspecialization, then I fear for the future of our specialty as a whole.

**Bruce Sigsbee, Rockport, ME:** The need for and growth of the UCNS is a reflection of the rapid growth of knowledge in all subspecialty areas of neurology.<sup>1</sup> However, general neurology is not dying. Rather, the importance of neurologists grounded in the wide spectrum of neurologic disease is expanding. While many neurologic groups are looking for subspecialty expertise, those individuals still need to care for all neurologic patients. Many academic departments are expanding general neurologic sections. Patients do not arrive with labels. The Massachusetts General Neurology Department has a general neurology fellowship.

An AAN general neurology taskforce completed a report to the AAN Board.<sup>1</sup> One of the key conclusions was that training programs and the AAN must support training and education for the generalist. The rapidly expanding concepts of disease and treatment options create immense challenges for the generalist. Subspecialization in neurology will continue to expand. One of our challenges as a specialty is to figure out how general neurologists can be trained in and remain current in this dynamic specialty.

**Author Response: Paul Vespa, Los Angeles; Stephen M. Sergay, Tampa, FL; John H. Kohring, St. Paul:** The authors agree with Dr. Sigsbee that the general neurologist is the backbone of the specialty, and that training for the generalist should continue to be supported by the AAN. The UCNS was established as a resource for those who choose subspecialization. We believe that subspecialization complements general neurology. General Neurology is an AAN section which is represented on the Committee on Sections.

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### CORRECTION

#### **WriteClick: Longitudinal assessment of oxaliplatin-induced neuropathy**

In the WriteClick discussion of “Longitudinal assessment of oxaliplatin-induced neuropathy” by S.B. Park et al. (*Neurology*® 2012;78:152), there is an omission in the author list, which should have included Cindy S.-Y. Lin and Matthew C. Kiernan. The editorial staff regrets the omission.