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DUCKS IN A ROW

Richard Dasheiff, Dallas: I applaud Friedman et al.¹ on their attempt to clarify and improve the conceptualization of PTCS. In this process, they inadvertently stumbled over the supporting and ancillary data. Table 1, even with references, is a reflection of inadequate understanding and inappropriate use of associations made between a given disease/syndrome and potential etiologies. For example, many patients have renal failure, anemia, sleep apnea, and Down syndrome, but PTCS is rare, and the cause and effect relationship is unknown in patients who have both. To further impugn the table, sleep apnea is not a disorder of hypercapnia—nor hypoxia—but fractionated sleep causing excessive daytime sleepiness.² If authors wish to convince readers to adopt a new classification system and diagnostic criteria, then all their ducks must be in a row. The article would

have been better without table 1 as it needs improvement.

Author Response: Deborah I. Friedman, Dallas; Grant T. Liu, Philadelphia; Kathleen B. Digre, Salt Lake City: The goal of our article was to clarify the diagnostic criteria for PTCS and provide a list of commonly associated secondary conditions.¹ The associated conditions listed are exactly that—associations—and we did not mean to imply that they were causal. A discussion of etiology and pathogenesis is beyond the scope of our article, yet the list of associations provides no real clues as to the mechanism of developing intracranial hypertension. However, PTCS and IIH are rare disorders. It could be argued, and we often do, that IIH is a disorder affecting obese women of childbearing age. There are many women around the world who fit that description but very few develop IIH. There may be a genetic component that makes some women susceptible and we eagerly await the results of the IIH trial for more answers.

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Ducks in a row

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