

Editors' Note: This week's WriteClick considers 2 diagnostic disagreements. Dr. Selmonosky and authors Simon et al. discuss the controversy around the diagnosis of thoracic outlet syndrome. Drs. Wall and Corbett argue against the need for new criteria for the diagnosis of idiopathic intracranial hypertension and include the modified Dandy criteria used in the Intracranial Hypertension Treatment Trial. Authors Friedman et al. support the revised criteria described in their original article.

—Megan Alcauskas, MD, and Robert C. Griggs, MD

SONOGRAPHIC DIAGNOSIS OF TRUE NEUROGENIC THORACIC OUTLET SYNDROME

Carlos A. Selmonosky, Falls Church, VA: The report by Simon et al.¹ contributes to the confusion about the diagnosis of thoracic outlet syndrome (TOS). They described a complication of a predominant uncomplicated neurogenic form that went undiagnosed for a long time. Early diagnosis of TOS will hopefully prevent the complications that are easily diagnosed but often too late. A new classification of TOS is well-described.² Knowledge of the forms and types—especially the uncomplicated form—will aid clinicians in the diagnosis of TOS before complications occur. Almost all cases present with mixed symptoms and signs of neurogenic, arterial, and venous compression.

Author Response: Neil G. Simon, Jeffery W. Ralph, Michel Kliot, San Francisco: The authors thank Dr. Selmonosky for emphasizing the ongoing debate on TOS diagnosis. We disagree that our recent study¹ contributes to the confusion. We believe that our findings highlight an emerging technology for the anatomical diagnosis of nerve injury and compression, including that in neurogenic TOS.

True neurogenic TOS has a characteristic presentation and pattern of abnormalities on electrodiagnostic studies.³ However, vascular TOS is rare and evidence of positionally induced vascular compromise (i.e., Adson sign) may be seen in a majority of healthy subjects.⁴ In addition, presentations characterized as “disputed TOS” are nonspecific and cannot be objectively verified,⁵ and overlap with other musculoskeletal pathologies involving the neck and shoulder region.

Neurologic diagnoses must be supported by rigorous, peer-reviewed data. This is vital because patients with erroneous diagnoses of TOS may seek surgical intervention that may result in further morbidity and health care costs.

© 2014 American Academy of Neurology

1. Simon NG, Ralph JW, Chin C, Kliot M. Sonographic diagnosis of true neurogenic thoracic outlet syndrome. *Neurology* 2013;81:1965.
2. Welcome to thoracic outlet syndrome. Available at: www.tos-syndrome.com. Accessed December 9, 2013.
3. Tsao BE, Ferrante MA, Wilbourn AJ, Shields RW Jr. The electrodiagnostic features of true neurogenic thoracic outlet syndrome. *Muscle Nerve* 2014;49:724–727.
4. Sanders RJ, Hammond SL, Rao NM. Diagnosis of thoracic outlet syndrome. *J Vasc Surg* 2007;46:601–604.
5. Wilbourn AJ. The thoracic outlet syndrome is overdiagnosed. *Arch Neurol* 1990;47:328–330.

REVISED DIAGNOSTIC CRITERIA FOR THE PSEUDOTUMOR CEREBRI SYNDROME IN ADULTS AND CHILDREN

Michael Wall, Iowa City; James J. Corbett, Jackson, MS: Friedman et al.¹ suggested new criteria for the diagnosis of idiopathic intracranial hypertension (IIH) syndrome and IIH. We believe that the current nomenclature and the Idiopathic Intracranial Hypertension Treatment Trial (IIHTT) are simpler, accurate, aptly descriptive, and modifiable.

Diseases or syndromes should be named for what they are—“idiopathic intracranial hypertension”—rather than what they are not—“idiopathic intracranial hypertension,” “primary idiopathic intracranial hypertension,” or “idiopathic intracranial hypertension syndrome (PTCS).” Many years ago, we visited the National Eye Institute and were told “we are not going to fund a pseudo anything.” We do not believe there is need for the term PTCS.

Secondary causes of intracranial hypertension should also be called what they are, such as vitamin A–induced intracranial hypertension, tetracycline-induced intracranial hypertension, or steroid withdrawal–related intracranial hypertension, rather than subsuming them with the PTCS acronym. When criteria for IIH are not met and no secondary cause is found, “intracranial hypertension of unknown cause” should be used. The naming

Neurology[®]

Sonographic diagnosis of true neurogenic thoracic outlet syndrome

Carlos A. Selmonosky, Neil G. Simon, Jeffery W. Ralph, et al.

Neurology 2014;83;198

DOI 10.1212/WNL.0000000000000559

This information is current as of July 7, 2014

| | |
|---|---|
| Updated Information & Services | including high resolution figures, can be found at: http://n.neurology.org/content/83/2/198.1.full |
| References | This article cites 4 articles, 1 of which you can access for free at: http://n.neurology.org/content/83/2/198.1.full#ref-list-1 |
| Permissions & Licensing | Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.neurology.org/about/about_the_journal#permissions |
| Reprints | Information about ordering reprints can be found online: http://n.neurology.org/subscribers/advertise |

Neurology® is the official journal of the American Academy of Neurology. Published continuously since 1951, it is now a weekly with 48 issues per year. Copyright © 2014 American Academy of Neurology. All rights reserved. Print ISSN: 0028-3878. Online ISSN: 1526-632X.

