

➔ Abstracts

Articles appearing in the February 2018 issue

Practice current: When do you suspect autoimmune encephalitis and what is the role of antibody testing?

Diagnosing autoimmune encephalitis (AE) is complicated by several factors, including issues with availability, sensitivity, and specificity of antibody testing, particularly with variability in assay techniques and new antibodies being rapidly identified; nonspecific findings on MRI, EEG, and lumbar puncture; and competing differential diagnoses. Through case-based discussions with 3 experts from 3 continents, this article discusses the challenges of AE diagnosis, important clinical characteristics of AE, preferences for methods of autoantibody testing and interpretation, and treatment-related questions. In particular, we explore the following question: If a patient's clinical presentation seems consistent with AE but antibody testing is negative, can one still diagnose the patient with AE? Furthermore, what factors does one consider when making this determination, and should treatment proceed independent of antibody testing in suspected cases? The same case-based questions were posed to the rest of our readership in an online survey, the results of which are also presented.

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Pilot study of volume-contracted state and hospital outcome after stroke

Background An increasing body of research suggests that acute stroke patients who are dehydrated may have worsened outcomes, though few have evaluated this relationship in the United States, where care structures and stroke risk profiles may vary. We sought to explore the relationship between a volume-contracted state (VCS) at the time of ischemic stroke and hospital outcomes as compared with euvolemic patients.

Methods We enrolled a consecutive series of ischemic stroke patients from a single academic stroke center within 12 hours from stroke onset. VCS was defined via surrogate markers (blood urea nitrogen/creatinine ratio >15 and urine specific gravity >1.010). The primary outcome was change in NIH Stroke Scale (NIHSS) score from admission to discharge. Multivariable analyses included adjustment for demographics and infarct size.

Results Over an 11-month study period, 168 patients were eligible for inclusion. Of the 126 with complete laboratory and MRI data, 44% were in a VCS at the time of admission. Demographics were similar in both the VCS and euvolemic groups, as were baseline NIHSS scores (6.7 vs 7.3; $p = 0.63$) and infarct volumes (12 vs 16 mL; $p = 0.48$). However, 42% of patients in a VCS demonstrated early clinical worsening, compared with 17% of the euvolemic group ($p = 0.02$). A VCS remained a significant predictor of worsening NIHSS in adjusted models (odds ratio 4.34; 95% confidence interval 1.75–10.76).

Conclusions Acute stroke patients in a VCS demonstrate worse short-term outcomes compared to euvolemic patients, independent of infarct size. Results suggest an opportunity to explore current hydration practices.

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Practice Current

Our survey on the topic “When do you suspect autoimmune encephalitis and what is the role of antibody testing?” has received over 1,000 responses from over 80 countries. Explore this topic and others on our redesigned website; compare your practice with peers and see survey results displayed on an interactive world map.

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