WHAT'S HAPPENING IN

Neurology® Clinical Practice

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Abstracts

Ataxic-hypotonic cerebral palsy in a cerebral palsy registry: Insights into a distinct subtype

Background To specifically report on ataxic-hypotonic cerebral palsy (CP) using registry data and to directly compare its features with other CP subtypes.

Methods Data on prenatal, perinatal, and neonatal characteristics and gross motor function (Gross Motor Function Classification System [GMFCS]) and comorbidities in 35 children with ataxic-hypotonic CP were extracted from the Canadian Cerebral Palsy Registry and compared with 1,804 patients with other subtypes of CP.

Results Perinatal adversity was detected significantly more frequently in other subtypes of CP (OR 4.3, 95% CI 1.5–11.7). The gestational age at birth was higher in ataxic-hypotonic CP (median 39.0 weeks vs 37.0 weeks, $p = 0.027$). Children with ataxichypotonic CP displayed more intrauterine growth restriction (OR 2.6, 95% CI 1.0–6.8) and congenital malformation (OR 2.4, 95% CI 1.2–4.8). MRI was more likely to be either normal (OR 3.8, 95% CI 1.4–10.5) or to show a cerebral malformation (OR 4.2, 95% CI 1.5–11.9) in ataxic-hypotonic CP. There was no significant difference in terms of GMFCS or the presence of comorbidities, except for more frequent communication impairment in ataxic-hypotonic CP (OR 4.2, 95% CI 1.5–11.6).

Conclusion Our results suggest a predominantly genetic or prenatal etiology for ataxic-hypotonic CP and imply that a diagnosis of ataxic-hypotonic CP does not impart a worse prognosis with respect to comorbidities or functional impairment. This study contributes toward a better understanding of ataxic-hypotonic CP as a distinct nosologic entity within the spectrum of CP with its own pathogenesis, risk factors, clinical profile, and prognosis compared with other CP subtypes.

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Neurology consults in emergency departments: Opportunities to streamline care

Background To use the variations in neurology consultations requested by emergency department (ED) physicians to identify opportunities to implement multidisciplinary interventions in an effort to reduce ED overcrowding.

Methods We retrospectively analyzed ED visits across 3 urban hospitals to determine the top 10 most common chief complaints leading to neurology consultation. For each complaint, we evaluated the likelihood of consultation, admission rate, admitting services, and provider-to-provider variability of consultation.

Results Of 145,331 ED encounters analyzed, 3,087 (2.2%) involved a neurology consult, most commonly with chief complaints of acute-onset neurologic deficit, subacute neurologic deficit, or altered mental status. ED providers varied most in their consultation for acute-onset neurologic deficit, dizziness, and headache. Neurology consultation was associated with a 2.3-hour-longer length of stay (LOS) (95% CI: 1.6–3.1). Headache in particular has an average of 6.7-hour longer ED LOS associated with consultation, followed by weakness or extremity weakness (4.4 hours) and numbness (4.1 hours). The largest estimated cumulative difference (number of patients with the specific consultation multiplied by estimated difference in LOS) belongs to headache, altered mental status, and seizures.

Conclusion A systematic approach to identify variability in neurology consultation utilization and its effect on ED LOS helps pinpoint the conditions most likely to benefit from protocolized pathways.

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Practice Buzz

Practice Buzz: Giving Voice to Neurology Professionals Worldwide was launched in June 2020 to accommodate multiple, time-sensitive topics using a flexible, agile digital platform not tied to print publication. The worldwide surveys focus on targeted questions for health care providers in neurology ranging from hot topics in clinical practice to contemporary issues in work/life balance and blind spots in topics of inclusion, equity, and diversity.

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