N20. Two more recent studies on N20 in cardiac arrest patients have found 0% false-positive rates (reporting on 13 and 33 patients, respectively).[3,6]

In view of these recent studies, we agree with Dr. Rothstein that SSEPs are a valuable prognostic parameter, even in hypothermia patients. Pooled analysis of the mentioned SSEP studies on hypothermia patients[1,2,3,6] gives a 1.2% false-positive rate (1/85), which falls within the 95% confidence interval for nonhypothermia patients.[8]

However, a potential bias remains. As prognostic parameters established in nonhypothermia patients are used for treatment decisions, studies on hypothermia patients could become a self-fulfilling prophecy[6]; if bilateral negative N20 leads to withdrawal of care, its predictive value for poor outcome might be overestimated.

While recent studies—including our own—suggest that only a small minority of patients may recover despite absent N20, it is important to establish this fact more reliably. Finally, the timing of SSEP recordings after cardiac arrest should be reevaluated to avoid false decisions in individual patients.

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1. Leithner C, Ploner CJ, Hasper J, Storm C. Does hypothermia influence the predictive value of bilateral absent N20 after cardiac arrest? Neurology 2010;74:965–969.
2. Tiainen M, Kovala TT, Takkunen OS, Roine RO. Somatosensory and brainstem auditory evoked potentials in cardiac arrest patients treated with hypothermia. Crit Care Med 2005;33:1736–1740.
3. Bouwes A, Binnekade JM, Zandstra DF, et al. Somatosensory evoked potentials during mild hypothermia after cardiopulmonary resuscitation. Neurology 2009;73:1457–1461.
4. Robinson LR, Micklesen PJ, Tirschwell DL, Lew HL. Predictive value of somatosensory evoked potentials for awakening from coma. Crit Care Med 2003;31:960–967.
5. Rothstein TL. The role of evoked potentials in anoxic-ischemic coma and severe brain trauma. J Clin Neurophysiol 2000;17:486–497.
6. Rossetti AO, Oddo M, Logroscino G, Kaplan PW. Prognostication after cardiac arrest and hypothermia: a prospective study. Ann Neurol 2010;67:301–307.
7. Steffen IG, Hasper D, Ploner CJ, et al. Mild therapeutic hypothermia alters neuron specific enolase as an outcome predictor after resuscitation: 97 prospective hypothermia patients compared to 133 historical non-hypothermia patients. Crit Care 2010;14:R69.
8. Wijdicks EF, Hijdra A, Young GB, Bassetti CL, Wiebe S, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: prediction of outcome in comatose survivors after cardiopulmonary resuscitation (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006;67:203–210.

CORRECTION

Clinical and biochemical features of aromatic L-amino acid decarboxylase deficiency

In the article "Clinical and biochemical features of aromatic L-amino acid decarboxylase deficiency" by L. Brun et al. (*Neurology*® 2010;75:64–71), there was a dosage error in the article text, in the Discussion, related to the dosage of trihexyphenidyl. On page 69, the section beginning with the 6th sentence of the second full paragraph on that page should read: "The therapy with trihexyphenidyl should start at a dosage of 0.03 mg/kg per day, divided in 3 doses. The dosage should then be increased by 0.03 mg/kg per day each week until the child shows any improvement, the child develops side effects, or a limit of 0.5 mg/kg per day is reached. In adolescents and adults, total daily doses exceeding 15 mg should be used with caution." The authors regret the error. This error was corrected online on July 28, 2010.