WriteClick: Editor's Choice

Editors' Note: In reference to "Predicting outcome after acute basilar artery occlusion based on admission characteristics" by Drs. Greving et al., Drs. He and Li argue against a 9-hour treatment window for intra-arterial therapy, against the use of recanalization as a predictor of outcome, and for the development of prediction models for different treatment strategies. The authors respond. Drs. Li et al. comment on the new American Academy of Neurology guideline on IV immunoglobulin (IVIg) for neuromuscular disorders, pointing out where evidence is still lacking on the use of IVIg in myasthenia gravis.

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

PREDICTING OUTCOME AFTER ACUTE BASILAR ARTERY OCCLUSION BASED ON ADMISSION CHARACTERISTICS

Yingkun He, Tianxio Li, Zhengzhou, China: Greving et al.[1] composed a prognostic model to predict outcome of acute basilar artery occlusion (BAO). There are some problems to be resolved before utilization.

First, according to the results of the Basilar Artery International Cooperation Study (BASICS), all 31 cases with a severe deficit and 16/22 cases with a mild to moderate deficit had a poor outcome with intra-arterial therapy (IAT) when the time to treatment exceeded 9 hours.[2] Should we recommend 9 hours as the time window for treating acute BAO with IAT?

Second, the BASICS results showed recanalization protected against poor outcome in IAT and IV thrombolysis (IVT) groups.[2] Recanalization is an extremely important factor but is not used as a predictor in these 3 models.[1]

Third, did those cases with or without occlusion and presence of prodromal minor stroke get aggressive medical therapy? If they did, aggressive medical therapy might protect more cases from stroke or occlusion and prodromal minor stroke would not only be a predictive factor but also a protective factor.[3]

Finally, different hospitals or centers have frequently used treatment strategies for various conditions, especially in developing countries. For these reasons, different prediction models for different treatment strategies will be necessary.

Author Response: Wouter J. Schonewille, Jacoba P. Greving, L.J. Kappelle, A. Algra, Utrecht, the Netherlands: We appreciate the interest of Drs. He and Li and response to our prognostic article.[1] We agree that recanalization is an important predictor of outcome. However, our focus was on those factors available at the time of admission.

Our prediction model is meant to be used prior to the initiation of therapy. The results from the BASICS registry showed that type of treatment had no significant influence on outcome at 1 month.[2] Our data do not enable any recommendations to be made with regard to the choice between IVT vs IAT in any time window.

We agree that the design of a prediction model for different treatment strategies is a high priority, but should await the results from the recently initiated BASICS trial.[4] In the meantime, we recommend treating patients with BAO with IVT. Additional IAT could be considered within a time window of 6 hours from the onset of a severe deficit. Little gain is expected in the 6- to 9-hour time window, but IAT could be considered in selected cases. The 28% good outcome rate among IA-treated patients with a mild to moderate deficit suggests there is still potential gain of IAT beyond the 9-hour time window. Primary IAT should only be considered in patients with a contraindication for IVT.

1. Greving JP, Schonewille WJ, Wijman CA, Michel P, Kappelle LJ, Algra A. Predicting outcome after acute basilar artery occlusion based on admission characteristics. Neurology 2012;78:1058–1063.
2. Schonewille WJ, Wijman CA, Michel P, et al. Treatment and outcomes of acute basilar artery occlusion in the Basilar Artery International Cooperation Study (BASICS): a prospective registry study. Lancet Neurol 2009;8:724–730.
3. Chimowitz MI, Lynn MJ, Derdeyn CP, et al. Stenting versus aggressive medical therapy for intracranial arterial stenosis. N Engl J Med 2011;365:993–1003.
4. Basilar Artery International Cooperation Study (BASICS) trial. Available at: http://basicstrial.com/. Accessed August 11, 2012.

Predicting Outcome after Acute Basilar Artery Occlusion Based on Admission Characteristics

Yingkun He, Wouter J. Schonewille, Tianxio Li, et al.

Neurology 2012;79;1410
DOI 10.1212/WNL.0b013e31826e1238

fracture risk assessment (FRAX) and falls assessment annually, with a baseline bone mineral density scan to identify those at high risk of osteoporotic fracture. Potential contributors to fracture risk should be avoided where possible, and interventions to improve both bone health and falls risk should be routine.

Author Response: Marloes T. Bazelier, Frank de Vries, Utrecht, the Netherlands: We appreciate the comments by Dobson et al. and agree with their concerns about the use of anxiolytics/hypnotics and antidepressants in patients with MS. These medication types have been associated with falls and (hip) fractures.[7,8] However, there is no evidence that discontinuation of these drugs would prevent fractures. We also agree that epidemiologic evidence for the underlying etiology of glucocorticoid use and risk of fractures in patients with MS is unclear.[4,6] Because patients with MS are already at risk of fracture, FRAX scores may be underestimated. Unfortunately, FRAX has not been designed specifically for patients with MS. We have recently published a clinical risk score that has been developed for fracture risk assessment in patients with MS.[9]

1. Bazelier MT, van Staa TP, Uitdehaag BM, et al. Risk of fractures in patients with multiple sclerosis: a population-based cohort study. Neurology 2012;78:1967–1973.
2. Ensrud KE, Blackwell TL, Mangione CM, et al. Central nervous system-active medications and risk for falls in older women. J Am Geriatr Soc 2002;50:1629–1637.
3. Vestergaard P, Rejnmark L, Mosekilde L. Anxiolytics, sedatives, antidepressants, neuroleptics and the risk of fracture. Osteoporos Int 2006;17:807–816.
4. Bazelier MT, van Staa T, Uitdehaag BM, et al. The risk of fracture in patients with multiple sclerosis: the UK general practice research database. J Bone Miner Res 2011;26:2271–2279.
5. Schwid SR, Goodman AD, Puzas JE, McDermott MP, Mattson DH. Sporadic corticosteroid pulses and osteoporosis in multiple sclerosis. Arch Neurol 1996;53:753–757.
6. Bazelier MT, Bentzen J, Vestergaard P, et al. The risk of fracture in incident multiple sclerosis patients: The Danish National Health Registers. Mult Scler 2012 Epub Apr 3.
7. Verdel BM, Souverein PC, Egberts TC, van Staa TP, Leufkens HG, de Vries F. Use of antidepressant drugs and risk of osteoporotic and non-osteoporotic fractures. Bone 2010;47:604–609.
8. van den Brand MW, Pouwels S, Samson MM, et al. Use of antidepressants and the risk of fracture of the hip or femur. Osteoporos Int 2009;20:1705–1713.
9. Bazelier MT, van Staa TP, Uitdehaag BM, et al. A simple score for estimating the long-term risk of fracture in patients with multiple sclerosis. Neurology 2012;79:922–928.

CORRECTIONS

Plasma multianalyte profiling in mild cognitive impairment and Alzheimer disease

In the article "Plasma multianalyte profiling in mild cognitive impairment and Alzheimer disease" by W.T. Hu et al. (Neurology® 2012;79:897–905), there is an error in the first paragraph on page 899. The third sentence should read "At WU, blood was collected in EDTA in polypropylene tubes after overnight fasting between 7:30 and 8:00 AM and centrifuged (2,000 *g* × 15 minutes at 4°C) for separation into plasma and cellular components." The authors regret the error.

Write*e*Click: Editor's Choice: Predicting outcome after acute basilar artery occlusion based on admission characteristics

In the correspondence regarding the article "Predicting outcome after acute basilar artery occlusion based on admission characteristics" by Y. He et al. (*Neurology*® 2012;79:1410), there is an error in the second author's name, which should be spelled "Tianxiao Li." The editorial staff regrets the error.

Author disclosures are available upon request (journal@neurology.org).