

# CARPHOLOGY by Rajendra



Pract Neurol 2007; 7: 206

## Head injury—to scan or not to scan

We already have the New Orleans criteria and the Canadian CT head rule. We now have a Dutch rule to help clinicians decide which patients with minor head injuries should have a CT brain scan, which they say is indicated if one major or two minor criteria are present. This rule can be used in patients who may or may not have lost consciousness and is based on a large prospective study of 3181 adults with minor head injury. The risk factors studied are mostly the usual suspects from the other rules such as age; the Glasgow Coma Scale score; skull fracture; post-traumatic vomiting; amnesia; or seizure. The rule successfully identified patients who had intracranial CT findings of injury (sensitivity, approximately 95%) or needed neurosurgical intervention (sensitivity, 100%) but it has still to be externally validated. None of these rules will work if clinicians miss a risk factor during history taking or examination.

*Ann Intern Med* 2007;**146**:397–405.

## Negligence claims: neurological/neurosurgical cases top of the league

A retrospective review of 559 cases from the NHS Litigation Authority database, which holds data on negligence claims against NHS clinicians from 1995 to 2005, finds many interesting bits of information. The specialty most frequently cited was neurosurgery (241) followed by neurology (172). Non-neurologists and non-neurosurgeons were the defendant in 146 cases. The most common pathologies were intervertebral disc disease (27%), CNS tumours (21%), CNS infection (11%) and subarachnoid haemorrhage (9%). The total cost for all closed claims was £37 million.

*Eur J Neurol* 2007;**14**:399–402.

## Which drug for seizures?

Two large multicentre unblinded randomised controlled trials in the UK find that for partial seizures the drug of choice should be lamotrigine, while for generalised seizures valproate should remain the preferred drug. The primary outcome measure

was time to treatment failure due to either failure to control the seizures or adverse drug effects. The partial seizures study was done on over 1700 patients in whom carbamazepine was considered to be the standard treatment. The patients were randomised to carbamazepine, gabapentin, lamotrigine, oxcarbazepine, or topiramate. The generalised seizure study was done on over 700 patients in whom valproate was considered to be the standard treatment and the patients were randomised to valproate, lamotrigine or topiramate.

*Lancet* 2007;**369**:1000–15; 1016–26.

## Lamotrigine and SUDEP

A small study records four consecutive instances of sudden unexpected death in epilepsy in non-hospitalised patients who were being treated with lamotrigine only at a University hospital in Norway between 1995 and 2005. All four were women with idiopathic epilepsy. The authors say more research is needed to find out if there is an association between lamotrigine and an increased risk of cardiac death.

*Acta Neurol Scand* 2007;**115**:199–203.

## Ataxia in multiple sclerosis

Another Cochrane review comes up with predictable findings. It looks at the treatment of ataxia in multiple sclerosis. The reviewers found 10 randomised controlled trials that met their inclusion criteria. Six placebo-controlled studies evaluated pharmacotherapy, three comparative studies looked at neuro-rehabilitation, and one at stereotactic neurosurgery. No standardised outcome measure was used across the studies. The authors conclude that in general, pharmacotherapies are unrewarding and data on neurosurgery and rehabilitation are insufficient to lead to a change in practice. So more research is needed—what else?

*Cochrane Database Syst Rev* 2007;**1**:CD005029.

## Monogenic neurological disorders are rare

How common are monogenic Mendelian disorders in general neurology outpatients?

An observational study carried out at the Walton Centre for Neurology and Neurosurgery in Liverpool over a six-year period found 53 patients with 16 different diagnoses. Huntington's disease and neurofibromatosis type 1 were the commonest. According to the author this low frequency means that their care is best left to specialist clinics.

*Int J Clin Pract* 2007 Mar 16; (Epub ahead of print).

## Acute attack of migraine

Sumatriptan combined with naproxen sodium and given as a single, fixed-dose tablet for the treatment of an acute attack of migraine, was superior to monotherapy with either sumatriptan or naproxen sodium alone. This is the finding of two randomised, double-blind, parallel-group studies conducted among 1461 and 1495 patients at 118 US clinical centres who had migraine and received treatment for a moderate or severe attack of migraine. Patients were randomised to receive a single tablet containing sumatriptan and naproxen sodium; sumatriptan only; naproxen sodium only; or placebo. These trials are industry sponsored and the role of the sponsors is described as follows: GlaxoSmithKline and Pozen Inc provided financial and material support, monitoring, data collection and management, and data analysis to the authors and study investigators—make of this what you will.

*JAMA* 2007;**297**:1443–54.

## Postpartum headache

How many neurologists are aware of the causes of headache in the postpartum period? A small retrospective study of 95 women shows that tension-type headache or migraine occurred in 47% of them; pre-eclampsia/eclampsia in 24%; and spinal headache in 16%. Brain imaging was performed in 22 patients who had neurological deficits or failed to respond to initial treatment. Fifteen of them had abnormal findings; haemorrhage, thrombosis or vasculopathy occurred in 10 of them. None of the 95 women died.

*Am J Obstet Gynecol* 2007;**196**:318.e1–7.