In MS patients with INO, hyperintense lesions in MLF have been demonstrated in all patients on PD sequence, in 88% on T2-weighted imaging and in 44% on FLAIR sequences. In our patients the lesion in the MLF was detected only on PD coronal and FLAIR. Thus our recommendation in patients is to acquire PD sequence in addition to the other sequences in a patient with suspected INO.

**References**


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identified with the help of neuroimaging or multi-mode evoked potential studies in the absence of symptoms/signs). However, “focal or site-restricted forms” of ADEM are well known. Cases presenting with optic neuritis or myelitis alone have been reported. Solitary hemispheric lesions mimicking tumors have also been reported. Therefore, the term “disseminated” is not appropriate for all cases of ADEM.

The term “encephalomyelitis” is non-specific as it means inflammation in the brain and spinal cord indicating that the entire central nervous system is involved. However, many cases of ADEM do not have such a diffuse involvement and manifest with lesser degrees of involvement.

The term ADEM (a post-infections or post-vaccinial illness) does not indicate the etiology and therefore does not help in the differentiation of infections (viral) or allergic encephalomyelitis. In addition, it does not convey the fact that ADEM is a monophasic illness (as against multiple sclerosis which is recurrent in nature).

These observations point to the fact that ADEM is a term that is not appropriate for many patients diagnosed with it. There is a need to substitute it with a better term. “Monophasic immune-mediated central nervous system demyelination” is one suggestion from us.

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Time and cost: Are they the only contributors to poor rate of stroke thrombolysis

Sir,

The study published by Dr. Pandian in an urban industrial city like Ludhiana, showed that only 7% of patients reaching within 3 hours received rTPA after complete evaluation and thrombolysis couldn’t be given in 10% of the subjects due to non-affordability of the drug, which shows that in rest of about 35% of ischemic stroke patients, excluding hemorrhages and TIAs, thrombolysis was not done due factors beyond cost and time. In our study, of twenty patients presenting within three hours, nine (45%) patients presented within one hour, two (10%) within 1-2 hours and nine (45%) between 2-3 hours of the onset of the stroke. Of them, thirteen (65%) were ischemic strokes and though seven being eligible, none received thrombolysis. We found it interesting that none of the patients were explained the available option of thrombolytic therapy and the cost involved. This to some extent, could be due to reluctance on part of the physicians to provide thrombolysis to stroke patients though we did not use a questionnaire to analyze the physician factors. It appears that the poor rate of thrombolytic therapy in our country cannot be entirely blamed on the part of patients for their late presentation and non-affordability of rTPA. The onset of stroke is such a catastrophic event in majority of cases, with paralysis of limbs, inability to speak or loss of consciousness, that it will create a panic to the patients and their relatives, and they will be immediately rushed to the nearest available health facility. Hence, in an urban or more importantly in a rural setup, the primary care physician must explain to the patient’s relatives, the available treatment options, costs involved and the importance of time window, and refer them to an appropriate referral center which provides thrombolytic therapy. Even for the patients from rural areas, despite lack of adequate public transport facilities and ambulance services, a sizable number reached the referral center with the help of private transportation, which is reflected by as many as 20 (31%) of 64 rural patients reaching within 3 hours. Training programmes in the form of workshops and CME programmes need to be provided for the primary care physicians involved in the care of stroke patients, to encourage them to initiate thrombolysis in more number of strokes. The role of physicians is of paramount importance, in rendering thrombolytic therapy, in this new era of economic development, where more number of patients are able to reach the hospital within the time window and are able to afford the drug.

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