Editors' Note: In response to the defense by Heck et al. of the conservative management of ruptured lenticulostriate artery (LSA) aneurysms, Cai et al. suggest an international, multiple-center registry to better study this condition. Shirota et al. answer some of the points raised by Ramos et al. on transcranial magnetic stimulation (TMS) in Parkinson disease (PD) and agree that their suggestions would improve the quality of future clinical trials.

—Chafic Karam, MD, and Robert C. Griggs, MD

PEARLS & OY-STERS: SMALL BUT CONSEQUENTIAL: INTRACEREBRAL HEMORRHAGE CAUSED BY LENTICULOSTRIATE ARTERY ANEURYSM

Olivier Heck, René Anxionnat, Serge Bracad, Nancy, France: Cai et al.¹ described a case of ruptured LSA aneurysm treated with surgery after a hemorrhage recurrence. They concluded that urgent treatment was necessary to minimize rebleeding risks.

The surgical or endovascular treatment of these aneurysms is possible but risky as they are located deep in the brain and close to sensitive cerebral tissue.² Very few cases of ruptured LSA aneurysms are reported. Their natural history and specifically the risk of hemorrhage recurrence are unclear.³ Several cases of spontaneous involution free of hemorrhage recurrence have been reported.⁴

In our institution, we encountered 3 recent cases of ruptured LSA aneurysms revealed by deep cerebral hematomas and we treated them conservatively. There was no hemorrhage recurrence and follow-up angiography demonstrated spontaneous thrombosis in 2 of the 3 cases.

Our experience, which coincides with past studies, leads us to think that a conservative approach with accompanying angiographic monitoring may be proposed as first-line treatment. If an aneurysm then persists or grows, its occlusion should be considered. Nonetheless, other studies are needed to further strengthen the legitimacy of this strategy.

Author Response: Xuemei Cai, Steve Han, Steven Feske, Sherry Chou, Boston: Heck et al. described 3 patients with ruptured LSA aneurysms revealed by

deep cerebral hematomas. They were treated conservatively and did not have subsequent hemorrhage.

In our case report, despite optimal medical therapy including tight blood pressure control, our patient had intracerebral hemorrhage (ICH) expansion. The patient's surgery was performed without complication so both surgically and medically treated cases exist for this rare condition.

We agree with Heck et al. that ICH from this type of aneurysm is so rare that the natural history of this disease is unclear, particularly targeting patients who will go on to have spontaneous thrombosis and those who will rebleed. We both seem to make a good case for an international, multiple-center registry to better study this condition.

LSA aneurysms are easily missed and therefore likely underdiagnosed. Improving our diagnostic accuracy may improve our knowledge about prevalence and natural history of the disease and may improve patient outcomes in the future.

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SUPPLEMENTARY MOTOR AREA STIMULATION FOR PARKINSON DISEASE: A RANDOMIZED CONTROLLED STUDY

Vesper Fe Marie L. Ramos, Rainer W. Paine, Nivethida Thirugnanasambandam, Bethesda, MD: Shirota et al.¹ reported a large trial of repetitive TMS of the supplementary motor area (SMA) for PD. Stimulation was given weekly for 8 weeks, with a 3-arm design.

The authors did not report baseline Unified Parkinson's Disease Rating Scale (UPDRS) scores and

time of medication intake with respect to assessment times. Strong placebo effects in PD outline the need for sham stimulation and the 1-Hz paradigm. Break times during TMS may affect results.^{2,3} MRI guidance may better localize SMA for stimulation. Effects of interrater and intrarater variability on UPDRS scoring and the clinical significance of reported effects are unclear.

In future studies, relevant outcome measures should include patient preference to undergo TMS as an adjunct to medication. In addition, spiral analysis would be helpful, which has shown worsening after 10-Hz repetitive TMS to the SMA.⁴ Finally, the Timed Up and Go test could be given to assess falling risk.⁵

Author Response: Yuichiro Shirota, Masashi Hamada, Tokyo; Yoshikazu Ugawa, Fukushima, Japan: Ramos et al. raised a number of interesting points regarding our study. The primary endpoint of our study was the change in UPDRS part III from the baseline.¹ As shown in figure 2 and table 1, disease severity was similar among groups.¹ Assessment was performed in the “on” state, and the time of medication intake with respect to assessment times varied among patients, even though the intraindividual

trail-to-trail difference was very small. Our exploratory study proposed a brand-new stimulation protocol (1-Hz repetitive TMS over SMA). Its utility in everyday clinical settings needs to be determined in a more refined study. The suggestions raised by Ramos et al. will improve future trials.

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CORRECTION

Independent predictors of ischemic stroke in the elderly: Prospective data from a stroke unit

In the article “Independent predictors of ischemic stroke in the elderly: Prospective data from a stroke unit” by P. Forti et al. (*Neurology*® 2013;80:29–38), there is an error in the affiliations of Dr. G. Procaccianti and Dr. T. Sacquegna. The correct affiliation should read: Neurology Stroke Unit, IRCCS Institute of Neurological Sciences, Maggiore Hospital, Bologna, Italy. The authors regret the error.

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

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Supplementary motor area stimulation for Parkinson disease: A randomized controlled study

Vesper Fe Marie L. Ramos, Yuichiro Shirota, Rainer W. Paine, et al.

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