Editors' Note: In the study by Broeders et al. concerning cognitive impairment in Parkinson disease (PD), 2 different groups report their own experiences. Kano et al. propose that patients with rigidity-dominant PD may be more susceptible to developing cognitive impairment than those in the tremor-dominant group. The need to provide more specific inclusion and exclusion criteria and the need to use specific tests are Dr. Dyck's main concerns regarding the Dutch survey on small-fiber neuropathy.

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

EVOLUTION OF MILD COGNITIVE IMPAIRMENT IN PARKINSON DISEASE

Marina Picillo, Naples and Salerno; Paolo Barone, Maria Teresa Pellecchia, Salerno; Gabriella Santangelo, Caserta, Italy: Broeders et al.¹ reported on the evolution of mild cognitive impairment (MCI) in patients with de novo Parkinson disease (PD). We reported the prevalence of PD-MCI and its 2-year development in our study population.^{2,3} Seventy-nine de novo, drug-naïve parkinsonian patients were enrolled. Diagnosis was checked twice during the course of the study and 3 patients were excluded due to a revised diagnosis. Two years later, 61 patients participated in follow-up. According to recent criteria,⁴ PD-MCI occurred in 28/76 patients (36.8%) at baseline and in 26/61 patients (42.6%) at follow-up. According to PD dementia (PDD) criteria,⁵ none of the patients showed PDD. At baseline and 2-year follow-up, patients with MCI had lower Mini-Mental State Examination (MMSE) score (26.4 [2.1] vs 27.8 [1.6], $p = 0.004$, and 27 [2.5] vs 28 [1], $p = 0.04$, respectively) but not higher motor scores (Unified Parkinson's Disease Rating Scale [UPDRS]–III, Hoehn & Yahr) and mood symptoms (Hospital Anxiety and Depression Scale) than patients without PD-MCI. Compared to the study by Broeders et al., we found a lower percentage of PD-MCI at 2-year follow-up and no PDD. Furthermore, our patients with PD-MCI did not present with higher motor and mood scores than patients without PD-MCI. We speculate that these discrepancies could be due to the younger age at onset of our cohort (58.5 [8.3] vs 66.1 [10.1] years).

Osamu Kano, Ken Ikeda, Yasuo Iwasaki, Tokyo: Broeders et al.¹ reported a group of new patients diagnosed with PD. About one-third of these patients fulfilled the criteria for PD-MCI at the time of diagnosis. After 5 years, approximately 50% of the patients were without dementia. We studied cognitive function in patients with PD and analyzed the relationship between cognitive function and motor symptoms in PD.⁶ We assessed cognitive function by using the MMSE. The patients performed poorly on the MMSE, which suggests a relationship between severity of rigidity and memory impairments. Broeders et al. reported that patients with PD were evaluated using the UPDRS. We would like to know which part was used. We think that patients in the rigidity-dominant group are more susceptible to developing cognitive impairment than those in the tremor-dominant group. However, it was not clear from this study whether there was any relationship between cognitive impairment and parkinsonian symptoms.

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RISK FACTORS FOR DEMENTIA WITH LEWY BODIES: A CASE-CONTROL STUDY

Angel Golimstok, Buenos Aires: Boot et al.¹ studied several risk factors for dementia with Lewy bodies (DLB). We reported that the history of attention-

deficit/hyperactivity disorder (ADHD) symptoms in adults is a risk factor for DLB and not for Alzheimer disease.² It is striking that these symptoms were not mentioned in the article by Boot et al.² since our results need confirmation. Regardless, we think that the greater likelihood of having a history of depression or anxiety in patients with diagnosis of DLB would support our findings because the diagnosis of ADHD is often confused or overlaps with depression and anxiety. Comorbidity between these entities and the possibility of bias is well known.^{3–5} In this study, the possibility of such bias is heightened because the data for depression or anxiety were generated solely from medical history and ADHD is usually underreported.

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INCIDENCE AND PREVALENCE OF SMALL-FIBER NEUROPATHY: A SURVEY IN THE NETHERLANDS

Peter James Dyck, Rochester, MN: Peters et al.¹ described the prevalence and incidence of “pure

small-fiber sensory neuropathy” in a Dutch population. The data appear to be important but the criteria for the disease conditions being tallied remain unclear.

The authors stated: “SFN was diagnosed based on the presence of at least 2 of the following symptoms not otherwise explained: neuropathic pain (burning, shooting, or itching), sheet or sock intolerance, restless legs syndrome, autonomic dysfunction (Sicca syndrome, accommodation problems, hyperhidrosis or hypohidrosis, micturition disturbances, impotence or diminished ejaculation or lubrication, bowel disturbances, hot flushes, orthostatic dizziness, cardiac palpitations), and clinical signs of small-fiber damage (e.g., pinprick loss, thermal sensory loss, allodynia, or hyperalgesia), normal nerve conduction study, and reduced IENFD at the ankle or abnormal quantitative sensory testing thermal thresholds at the foot.”

Since small-fiber sensory and autonomic neuropathy may be asymptomatic, were these cases excluded from this diagnosis? In addition, were known causes (genetic mutations, autoimmune, metabolic, and other known causes) included or excluded? Perhaps the greatest concern is lack of specificity of symptoms and neuropathic signs and tests. Symptoms like palpitation, itching, and Sicca occur more commonly from other diseases than from small-fiber polyneuropathy.

Many of these symptoms are related to age, so were old age–related symptoms included? What specific criteria were used for signs and nerve tests? Descriptors such as abnormal nerve conduction are not specific enough: which attributes and what percentile abnormality? Providing more specific inclusion and exclusion criteria will make the data more useful.

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Risk factors for dementia with Lewy bodies: A case-control study

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