

**Reply from the Authors:** We thank Drs. Khandelwal and Nagar for their comments and for relating their experience with PNES in India. In our data, self-reported income level was similar between PNES and non-PNES subjects, suggesting that low socioeconomic status was not a chief substrate or predisposing factor for PNES in our population.

Interestingly, 28 (80%) of the 35 subjects who opted not to report income were epilepsy patients. Female predominance and sexual abuse history appear to be global themes in PNES. Patient-provided video recordings of events can help ascertain event semiology and certainly guide the experienced practitioner in the right direction. However, caution must be taken when relying on history or video alone to diagnose PNES or epilepsy as most epileptologists have experienced being deceived despite history or video.

One study reported that out of 89 seizure patients referred for VEEG, experienced neurologists and epileptologists misdiagnosed 22 PNES patients as having epilepsy and 4 epilepsy patients as having PNES prior to referral.<sup>2</sup> Short-term (2–3 hour) VEEG may correctly diagnose PNES if a habitual nonepileptic event is captured, yet may not rule out concomitant epilepsy, present in 5%–40% of PNES patients.<sup>3</sup>

On the other hand, short-term VEEG demonstrating interictal epileptiform activity without capturing habitual events identifies epilepsy but does not exclude PNES. Short-term VEEG that neither captures an event nor demonstrates interictal epileptiform activity is diagnostically inconclusive.

In our study, nearly all subjects underwent VEEG monitoring for at least 3 days, even when PNES was diagnosed on the day of admission, so that we could identify interictal epileptiform activity or frank epileptic seizures especially after AED discontinuation. In general, an experienced practitioner may correctly identify PNES in a significant number of cases using only history, patient-provided video, or 2–3 hour VEEG.

However, long-term VEEG should remain the gold standard of diagnosis because PNES and epilepsy may coexist.

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*Disclosure:* Dr. Syed serves on the speakers bureau for Pfizer. Dr. Alexopoulos serves on the speakers bureau for Pfizer and UCB, S.A.; has received support for investigator-initiated research from UCB, S.A., and from Dainippon Sumitomo Pharma; has received honoraria from the American Clinical Neurophysiology Society and the American Society of Electrodiagnostic Technologists; and serves as an Associate Editor of “The Ictal Zone,” the Official Newsletter of the Epilepsy Section of the AAN. Dr. Loddenkemper has received funding from the American Epilepsy Society/Milken Family Foundation and may hold stocks related to medical companies within mutual funds.

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### **CORRECTION**

#### **HIV-related immune reconstitution cryptococcal meningoradiculitis: Corticosteroid response**

In the Clinical/Scientific Note “HIV-related immune reconstitution cryptococcal meningoradiculitis: Corticosteroid response” by A. Brunel et al. (*Neurology*<sup>®</sup> 2009;73:1705–1707), A. Brunel should have been listed as A.S. Brunel. The authors regret the error.

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## **HIV-related immune reconstitution cryptococcal meningoradiculitis: Corticosteroid response**

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