

make other physicians aware of these adverse events so that appropriate treatment can be initiated.

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1. Yeung J, Cauquil C, Saliuo G, et al. Varicella-zoster virus acute myelitis in a patient with MS treated with natalizumab. *Neurology* 2013;80:1812–1813.

EVIDENCE-BASED GUIDELINE: TREATMENT OF TARDIVE SYNDROMES: REPORT OF THE GUIDELINE DEVELOPMENT SUBCOMMITTEE OF THE AMERICAN ACADEMY OF NEUROLOGY

Vladimir Lerner, Chanoch Miodownik, Be'er Sheva, Israel:

We read the article by Bhidayasiri et al.¹ with interest. We found some inaccuracies. The authors cited only one of our articles regarding treatment of tardive dyskinesia (TD).² Even though the authors performed a search from 1966 to 2011, they did not include 2 studies published in 2007 that could broaden the knowledge about new options for TD management.^{3,4} The first deals with vitamin B₆ and the other with piracetam. Both studies include large samples (50 and 40 subjects, respectively) and could be considered Class I evidence according to the authors' classification. Inclusion of this information could positively influence the weight and emphasize the significance of these medications. Our experience shows that different types of TD react uniquely to different types of medications.

Author Response: Roongroj Bhidayasiri, Bangkok, Thailand; Stanley Fahn, New York; Gary S. Gronseth, Kansas City, KS; Kelly L. Sullivan, Theresa A. Zesiewicz, Tampa, FL: We appreciate the authors' comments and interest in our article.¹ We agree that various forms of tardive syndromes (TDS) can respond to medications or interventions differently and that well-designed randomized controlled trials are needed.

Effective trials should feature specific TDS inclusion criteria and subtypes to determine the most effective interventions for TDS symptoms. As the authors

noted, 2 studies on vitamin B₆ and piracetam were not included in our original analysis.^{3,4} The first study, a double-blind, placebo-controlled trial on vitamin B₆ treatment in 50 inpatients with schizophrenia/schizoaffective disorders, was rated Class III for no allocation concealment and a >20% (14/50) dropout rate.³

The second study of 40 patients with schizophrenic/schizoaffective disorders who received piracetam or placebo over 4 weeks was rated Class III for the same reasons (9 dropouts).⁴ After applying the AAN's classification scheme for rating therapeutic articles,⁵ we found the data remain insufficient to support or refute use of vitamin B₆ and piracetam as TDS treatments.

Although the AAN endeavors to find all pertinent literature, as the AAN process manual prescribes,⁵ we realize that no literature search is completely effective, and we thank the authors for alerting us to these 2 studies. We corrected errors for an article cited in table e-1 and this table is updated online.²

Editor's Note: A Correction for this article is published on page 1966 of this issue.

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3. Lerner V, Miodownik C, Kaptan A, et al. Vitamin B6 treatment for tardive dyskinesia: a randomized, double-blind, placebo-controlled, crossover study. *J Clin Psychiatry* 2007;68:1648–1654.
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Author disclosures are available upon request (journal@neurology.org).

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Evidence-based guideline: Treatment of tardive syndromes: Report of the Guideline Development Subcommittee of the American Academy of Neurology

Vladimir Lerner, Roongroj Bhidayasiri, Chanoch Miodownik, et al.

Neurology 2013;81;1967

DOI 10.1212/01.wnl.0000439053.82390.26

This information is current as of November 25, 2013

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