fibrillation (AF). It may be helpful to include the details of the education provided to the professionals or patients who did self-measurement. Was the pulse rhythm irregularity measured by palpation of the radial artery?

Author Response: Bernd Kallmünzer, Martin Köhrmann, Erlangen, Germany: We thank Dr. Totah for his comments and interest. Screening for AF by peripheral pulse palpation is recommended by international guidelines for patients 65 years or older to prevent ischemic stroke. Among stroke survivors, the risk for paroxysmal AF is an expected 5–20 times higher than among cohorts of primary prevention and silent episodes are easily missed by single ECG diagnostics. Before this study, it was unclear if the peripheral pulse palpation technique was feasible and accurate among stroke survivors with cognitive and sensomotoric handicaps.

In our study, patients were offered a training program that provided basic information on paroxysmal AF and cardioembolic stroke. Participants were tutored on performing reliable pulse measurements at the radial artery. They were instructed to distinguish between absolute arrhythmic pulse sensation (indicative for paroxysmal AF) and regular peripheral pulse (indicative for a normal heart rhythm).

As Dr. Totah mentioned, the participants measured irregularities of the peripheral pulse at the radial artery and were then free to choose the side of measurement, depending on preexisting handicaps. This method could serve as a simple, noninvasive strategy to guide ECG diagnostics for secondary stroke prevention.

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DEFINING THE CLINICAL COURSE OF MULTIPLE SCLEROSIS: THE 2013 REVISIONS

Francois H. Jacques, Gatineau, Canada: I read with interest the article by Lublin et al. When defining disease subtypes—like neuromyelitis optica—it is clear that pathophysiology should take precedence over clinical and subjective descriptions. The subtypes proposed by Lublin et al. are arbitrary and often diagnosed retrospectively. There is pathophysiologic evidence suggesting that multiple sclerosis (MS) is a progressive disease from the onset and that inflammatory pathologic processes persist well into the progressive phases of the disease. The absence or decrease in remission is a sign of exhaustion of CNS compensatory mechanisms rather than a change in disease process. The negative interferon and glatiramer trials in progressive MS are more likely the result of combining modest drug efficacy with insensitive clinical endpoints (i.e., Expanded Disability Status Scale) vs a different disease mechanism. Newer trials such as INFORM and ASCEND should soon confirm this. MS subtypes should be replaced by MS stages (radiologically isolated syndrome through secondary progressive MS) or more simply MS with or without disease activity or with or without progression.

Author Response: Fred D. Lublin, New York: We thank Dr. Jacques for his interesting comments and hypotheses and await data to answer these questions. Our publication is in agreement with his suggestion to categorize MS by the presence of activity or progression.

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CORRECTION

Physical activity attenuates age-related biomarker alterations in preclinical AD

In the article “Physical activity attenuates age-related biomarker alterations in preclinical AD” by O.C. Okonkwo et al. (Neurology® 2014;83:1753–1760), there is an error in table 1. Under “Vascular indices,” the third row should read “Ever smoked, %,” rather than “Smoker, %” as originally published. The authors regret the error.

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Physical activity attenuates age-related biomarker alterations in preclinical AD

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