The term ictal epileptic headache,[5] instead of HE, should be used to define a migraine of epileptic origin in order to provide a framework for clinical diagnosis, investigation, and therapeutic approaches for each patient and to facilitate communication among clinicians.

Author Response: Zubeda Sheikh, East Rutherford; David Marks, Newark, NJ: We appreciate the comments of Belcastro et al. regarding our recent report.[1] In the ICHD-3 classification, headaches secondary to seizures were classified as HE or postictal headache.[6] Belcastro et al. suggested the term ictal epileptic headache for a headache that is the only ictal clinical manifestation of an epileptic seizure, is synchronous with the ictal EEG discharge, and responds to IV antiepileptic medications.[3,7] Belcastro et al. differentiate an ictal epileptic headache from HE, which they propose should be reserved for an epileptic headache either associated with or having synchronous or sequential sensorimotor manifestations.[8]

The patient described had prominent visual hallucinations, hemianopsia, and epileptic nystagmus accompanying the headache.[1] Due to the presence of these sensorimotor manifestations affecting the visual system, the diagnosis is more consistent with the diagnostic criteria outlined for HE rather than the criteria proposed for ictal epileptic headache. Until a better classification system for headaches caused by seizures is available, we propose the continued use of the ICHD-3 classification.

1. Sheikh Z, Georgsson H, Marks D. Pearls & Oy-sters: hemicrania epileptica: unfolding the mystery of an unremitting migraine. Neurology 2015;85:e190–e192.
2. Belcastro V, Striano P, Pierguidi L, Calabresi P, Tambasco N. Ictal epileptic headache mimicking status migrainosus: EEG and DWI-MRI findings. Headache 2011;51:160–162.
3. Parisi P, Verrotti A, Costa P, et al. Diagnostic criteria currently proposed for "ictal epileptic headache": perspectives on strengths, weaknesses and pitfalls. Seizure 2015;31:56–63.
4. Perucca P, Terzaghi M, Manni R. Status epilepticus migrainosus: clinical, electrophysiologic, and imaging characteristics. Neurology 2010;75:373–374.
5. Parisi P, Striano P, Trenite DG, et al. "Ictal epileptic headache": recent concepts for new classifications criteria. Cephalalgia 2012;32:723–724.
6. Headache Classification Committee of the International Headache Society (IHS). The international classification of headache disorders, 3rd edition (beta version). Cephalalgia 2013;33:629–808.
7. Belcastro V, Striano P, Kasteleijn-Nolst Trenite DG, Villa MP, Parisi P. Migralepsy, hemicrania epileptica, post-ictal headache and "ictal epileptic headache": a proposal for terminology and classification revision. J Headache Pain 2011;12:289–294.
8. Parisi P, Striano P, Villa MP, Belcastro V. Ictal epileptic headache: terms do matter in clinical practice! reply to Cianchetti et al. Cephalalgia 2013;33:426.

CORRECTIONS

Antibiotic-associated encephalopathy

In the Views & Reviews article "Antibiotic-associated encephalopathy" by S. Bhattacharyya et al. (Neurology 2016;86:963–971), there is an error in the paragraph prior to "Limitations." The last sentence should read "The use of iron, calcium, and aluminum supplements in patients with renal insufficiency can also alter gastrointestinal absorption of certain antibiotics such as quinolones[54]" rather than "increase" as originally published. The authors regret the error.

Use of amyloid-PET to determine cutpoints for CSF markers: A multicenter study

In the article "Use of amyloid-PET to determine cutpoints for CSF markers: A multicenter study" by M.D. Zwan et al. (Neurology 2016;86:50–58), concordance was incorrectly defined in the Methods section. The correct definition is "the proportion of individuals with an identical classification of both biomarkers, e.g., normal CSF biomarkers (not Alzheimer-like) (either $A\beta_{42}$ alone or $A\beta_{42}$/tau) and normal (negative) amyloid-PET or abnormal (Alzheimer-like) CSF biomarkers (either $A\beta_{42}$ alone or $A\beta_{42}$/tau) and abnormal (positive) amyloid-PET." In addition, the patient numbers described in the Results section under "Concordance between CSF $A\beta_{42}$/tau ratio and amyloid-PET" are incorrect and should have been 140, 218, 39, and 17, respectively, as shown in table 5. The authors regret the errors.

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