Let us analyze this text step by step:

1. **Editors’ Note:** In response to the article “Hand postures in primary and secondary generalized tonic-clonic seizures,” Dr. Mintzer explains why the statistical methodology employed by the authors, Fisher exact test with Bonferroni correction for multiple comparisons, was not ideal and that the version for multiple groups would have been preferable. He also reinforces a point brought up in a previous comment by Dr. Lanska: multiple events from the same patient should not be considered independent for the purpose of statistical analysis. Authors Siegel and Tatum describe how they addressed the problem statistically. Authors Uruha et al. report that the myxovirus resistance A (MxA) polyclonal antibodies used in their study, “Sarcoplasmic MxA expression: A valuable marker of dermatomyositis,” have been discontinued by the company that produced them. The authors describe the results of their tests into the company’s monoclonal antibody alternative, concluding that the alternative can be used comparably to the original, but may require higher concentrations.

—Megan Alcauskas, MD, and Robert C. Griggs, MD

2. **LETTER RE: HAND POSTURES IN PRIMARY AND SECONDARY GENERALIZED TONIC-CLONIC SEIZURES**

Scott Mintzer, Philadelphia: I congratulate Drs. Siegel and Tatum1 for the novel examination of hand postures in different seizure types. However, I have concerns that the statistical analysis was not done properly.

The authors reported the use of Fisher exact test with Bonferroni correction for multiple comparisons.1 Fisher exact test is most often used to analyze 2 × 2 contingency tables. There is a version for multiple groups, but it does not appear that it was used, as it would require the use of posttests and none were mentioned. The use of 3 sets of pairwise comparisons to compare 3 different groups violates the test assumptions. A more appropriate statistical practice is to use a test designed to compare multiple groups, followed by pairwise posttests if there is significance in the main test.

In addition, the concern raised by Dr. Lanska2 in a previous comment on this article was not adequately addressed by the authors.3 While the events may be considered independent from a clinical diagnostic standpoint, that does not make them independent from a statistical analysis standpoint. After all, it is the nature of the disease that seizures are stereotyped within a given patient.

Owing to these concerns, the p values reported by the authors may provide an inaccurate picture of statistical significance. The data should be reanalyzed.


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3. **AUTHOR RESPONSE: HAND POSTURES IN PRIMARY AND SECONDARY GENERALIZED TONIC-CLONIC SEIZURES**

Jason Siegel, William O. Tatum, Jacksonville, FL: We thank Dr. Mintzer for the interest in our article1 and for the comments on the statistical significance of our findings in response to our prior comment to Dr. Lanska.2,3

We agree that more complex 3-way statistics could be initially performed on the overall data; nevertheless, our statistical analysis used the pairwise approach to directly address the comparisons of greatest interest to us.

We appreciate the distinction pointed out between clinical and statistical independence to highlight the difference between them. To this point, we also used generalized estimating equation models to account for the potential correlation among variable independent seizures from different individual patients. The results using this metric were similar to our published results and served to validate the accuracy of our findings. Future prospective assessment analyzing 3 independent arms to study epilepsies and nonepileptic events may further validate our initial clinical findings.

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AUTHOR UPDATE: SARCOPLASMIC MXA EXPRESSION: A VALUABLE MARKER OF DERMATOMYOSITIS
Akinori Uruha, Shigeaki Suzuki, Ichizo Nishino, Tokyo: Soon after our article published,¹ we learned the sale of the myxovirus resistance A (MxA) polyclonal antibodies used in the study (Mx1/2/3 [H-285], sc-50509, Santa Cruz Biotechnology, Dallas, TX) had been discontinued. Furthermore, we received inquiries from several physicians concerning alternate MxA antibodies. We tested the company’s monoclonal antibody alternate (Mx1/2/3 [C-1], sc-166412) on frozen muscle sections at various dilutions in 2% bovine serum albumin in PBS using the Ventana immunohistochemistry detection system (Ventana Medical Systems, Tucson, AZ) with or without the enhancement mode. Muscle samples tested included MxA-positive dermatomyositis (n = 3, including 1 juvenile participant), MxA-negative dermatomyositis (n = 3), anti-Jo-1 myopathy (n = 3, MxA-negative), and immune-mediated necrotizing myopathy (n = 3, comprising 1 with anti-signal recognition particle antibodies [MxA-negative], 1 with anti-3-hydroxy-3-methylglutaryl-CoA reductase antibodies [MxA-negative], and 1 without those antibodies [MxA-positive]). We observed essentially the same staining pattern at comparable signal intensity as the original polyclonal antibodies at 1:10 dilution with the enhancement mode although the signal was barely detected at the manufacturer’s recommended dilution (starting dilution: 1:50), indicating that the monoclonal antibody alternate can be similarly used to detect sarcoplasmic MxA expression on frozen muscle sections for the diagnosis of dermatomyositis (although higher concentration is necessary).


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CORRECTIONS
Revisiting neurofibromatosis type 2 diagnostic criteria to exclude LZTR1-related schwannomatosis
In the article “Revisiting neurofibromatosis type 2 diagnostic criteria to exclude LZTR1-related schwannomatosis” by M.J. Smith et al.,¹ there are errors in table 4. Row 3 should have read: “FDR Family history of NF2 OR unilateral VS AND two of: meningioma, cataract, glioma, neurofibroma, nonvestibular schwannoma, cerebral calcification (if UVS > 2 nonintradermal schwannomas need negative LZTR1 test) OR.” Row 4 should have read: “Multiple meningioma (2 or more) AND unilateral VS OR two of: Cataract, glioma, neurofibroma, nonvestibular schwannoma, cerebral calcification OR.” The authors regret the errors.

REFERENCE

Autologous hematopoietic stem cell transplantation in multiple sclerosis: A meta-analysis
In the article “Autologous hematopoietic stem cell transplantation in multiple sclerosis: A meta-analysis” by M.P. Sormani et al.,¹ there is an error in figure 2. The label at the top of the right panel should have read “5-Year progression rate (%).” The authors regret the errors.

REFERENCE

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

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Revisiting neurofibromatosis type 2 diagnostic criteria to exclude LZTR1-related schwannomatosis

Neurology 2017;89:215
DOI 10.1212/WNL.0000000000004168

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