

→ Abstracts

Articles appearing in the June 2018 issue.

**Prevalence of and risk factors for cerebral microbleeds in a general Japanese elderly community**

**Background** We investigated the prevalence of and risk factors for cerebral microbleeds (CMBs) in a cross-sectional study of a general population of Japanese elderly.

**Methods** In 2012, brain MRI scanning at 1.5T and comprehensive health examination were conducted for 1,281 residents aged 65 years or older. CMBs were defined as ovoid hypointensity lesions less than 10 mm in diameter on T2\*-weighted images and classified into deep/infratentorial or lobar CMBs. Age- and sex-specific and overall prevalence of CMBs were estimated, and the associations of traditional cardiovascular risk factors and APOE polymorphism with the presence of CMBs were examined using a logistic regression analysis.

**Results** The crude prevalences of total, deep/infratentorial, and lobar CMBs were 18.7% (n = 240), 13.5% (n = 173), and 9.6% (n = 123), respectively. The prevalence of total CMBs was 23.0% in men and 15.5% in women and increased with aging in both sexes (both p for trend <.01). Hypertension was significantly associated with the presence of both deep/infratentorial and lobar CMBs. Lower serum total cholesterol was a significant risk factor for deep/infratentorial CMBs, but not for lobar CMBs, while APOE ε4 carriers had a significantly higher likelihood only of lobar CMBs compared with noncarriers.

**Conclusions** Our study suggests that approximately 1 of 5 Japanese elderly people have CMBs, and that risk factors for deep/infratentorial and lobar CMBs are different, indicating the distinct pathologic backgrounds of these lesions.

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**Early myoclonus following anoxic brain injury**

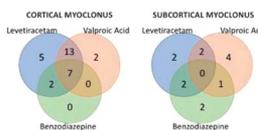
**Background** It is unknown whether postanoxic cortical and subcortical myoclonus are distinct entities with different prognoses.

**Methods** In this retrospective cohort study of 604 adult survivors of cardiac arrest over 8.5 years, we identified 111 (18%) patients with myoclonus. Basic demographics and clinical characteristics of myoclonus were collected. EEG reports, and, when available, raw video EEG, were reviewed, and all findings adjudicated by 3 authors blinded to outcomes. Myoclonus was classified as cortical if there was a preceding, time-locked electrographic correlate and otherwise as subcortical. Outcome at discharge was determined using Cerebral Performance Category.

**Results** Patients with myoclonus had longer arrests with less favorable characteristics compared to patients without myoclonus. Cortical myoclonus occurred twice as often as subcortical myoclonus (59% vs 23%, respectively). Clinical characteristics during hospitalization did not distinguish the two. Rates of electrographic seizures were higher in patients with cortical myoclonus (43%, vs 8% with subcortical). Survival to discharge was worse for patients with myoclonus compared to those without (26% vs 39%, respectively), but did not differ between subcortical and cortical myoclonus (24% and 26%, respectively). Patients with cortical myoclonus were more likely to be discharged in a comatose state than those with subcortical myoclonus (82% vs 33%, respectively). Among survivors, good functional outcome at discharge was equally possible between those with cortical and subcortical myoclonus (12% and 16%, respectively).

**Conclusions** Cortical and subcortical myoclonus are seen in every sixth patient with cardiac arrest and cannot be distinguished using clinical criteria. Either condition may have good functional outcomes.

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