Disputes & Debates: Editors’ Choice

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Editors’ Note: Association of Initial Imaging Modality and Futile Recanalization After Thrombectomy

In “Association of Initial Imaging Modality and Futile Recanalization After Thrombectomy,” Meinel et al. reported that the rate of futile recanalization (defined as 90-day modified Rankin Scale [mRS] score 4–6 despite successful recanalization) among patients enrolled in the BEYOND-SWIFT multicenter, retrospective observational registry was significantly higher in patients selected for thrombectomy based on a CT scan as compared with patients selected for thrombectomy based on an MRI. Siegler and Thon cautioned that these findings should not dissuade against (1) use of a CT scan to determine eligibility for thrombectomy because this could lead to unnecessary delays in care or (2) performance of thrombectomy after CT scans because the imaging modality itself does not directly affect outcome and 40% of patients selected for thrombectomy based on a CT scan had a good 90-day mRS score (which represents a 22%–27% absolute increase compared with patients treated with medical management in the DAWN and DEFUSE-3 trials). Meinel et al agreed that it is imperative to avoid delays before thrombectomy and reinforced that their findings should not influence the selection of imaging modality for potential thrombectomy candidates. They also pointed out that implementation of high-speed MRI protocols should be considered to obtain more detailed information than a CT scan can provide while avoiding lengthy delays between imaging and groin puncture.

Ariane Lewis, MD, and Steven Galetta, MD
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Reader Response: Association of Initial Imaging Modality and Futile Recanalization After Thrombectomy

James E. Siegler (Camden, NJ) and Jesse M. Thon (Camden, NJ)

We read with interest the results of the BEYOND-SWIFT retrospective observational registry by Meinel et al.1 Determination of candidacy for acute stroke intervention is a rapidly evolving and highly controversial field because we have seen in recently published trials, which are expanding eligibility criteria.

We would respectfully caution the authors to avoid using language such as “there is a need to reduce [futile recanalization]” in the opening of their article and to reiterate it verbatim in the Discussion because these are misleading proclamations. Certainly, it remains a priority among all clinicians to provide cost-effective care with the aim of improving functional outcomes and/or satisfying end-of-life preferences. However, to leverage “futile recanalization” to justify whether CT or MRI-based modalities be used in selecting thrombectomy candidates will undoubtedly bias clinicians in their imaging recommendations (leading to delays in care, as the investigators have shown). It may also falsely influence a clinician’s determination of thrombectomy eligibility. To conclude that CT-based selection of thrombectomy candidates results in a higher rate of futile
thrombectomy when compared with MRI-based methods (although accurate) is inherently misleading. We do not question the effect of imaging modality on treatment-related outcome. However, even among CT-based selection of patients from BEYOND-SWIFT, 40% of patients achieved functional independence by 90 days. This is a marginal 5%–9% decrement from what was observed in DAWN2 and DEFUSE-3,3 and (more importantly) a 22%–27% absolute increase in the rate of functional achievement of these patients when compared to medically managed controls from these trials.

To suggest that these patients are “futile recanalizers” is a misrepresentation and decontextualization of the data. Such claims could impede the care of many treatment responders, potentially growing the number of disabled stroke survivors or even resulting in medicolegal consequences for clinicians who justify treatment deferral based on these findings. It is worthwhile to consider CT versus MRI in predicting the long-term outcome after thrombectomy, but knowing that time is a critical determinant of functional outcomes in treated large vessel occlusion4 should encourage clinicians to rely on the quickest imaging assessment—in this case, CT.

considering only mRS 5–6 at 3 months as futile. This was done because there may be a higher consensus among physicians and also patients that mRS 5–6 despite successful reperfusion constitutes a futile treatment (5-Year QUALE 0.05). Given the fact that current guidelines judge MRI and CT equivalent, we doubt that an established MRI workflow will lead to medicolegal consequences.

We fully agree that time delays should be avoided and a potentially life-saving treatment should be offered to any patient fulfilling criteria for endovascular stroke treatment. Clinicians should be aware that the initial imaging modality might affect their treatment decisions. Whether MR imaging as compared with CT imaging leads to over-selection and time delays or that it harbors the potential to reduce futile interventions without over-excluding patients can only be evaluated in upcoming randomized controlled trials. Until then, our study should not influence clinicians to change the imaging modality for suspected thrombectomy candidates.

Reader Response: Comparison of Ice Pack Test and Single-Fiber EMG Diagnostic Accuracy in Patients Referred for Myasthenic Ptosis

Nicholas Silvestri (Buffalo)

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Giannoccaro et al.1 reported their findings on the sensitivity and specificity of the ice pack test and single-fiber electromyography (SF-EMG) in the diagnosis of ocular myasthenia gravis. It is interesting—and perhaps humbling—that such a straightforward test as cooling muscle with ice has very similar diagnostic accuracy compared with a technically complex and sophisticated test as SF-EMG in patients presenting with eyelid ptosis. These findings are largely in line with previous research evaluating the positive and negative predictive values of the ice pack test in ocular myasthenia gravis.2-5

One concern is the discordance in the results of the 2 tests in 10% of the study participants, although this occurred more often in cases of mild and isolated ptosis. Another limitation is that the authors did not assess the utility of the ice pack test in patients with isolated diplopia, a fairly common clinical manifestation in those ultimately diagnosed with ocular myasthenia.

Overall, the results of this study are encouraging given the simplicity of the ice pack test and a relatively limited availability of SF-EMG, and they highlight the continued importance of the physical examination in neurologic diagnosis in an age of extensive and often “shotgun” approach to diagnostic testing.


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Author Response: Comparison of Ice Pack Test and Single-Fiber EMG Diagnostic Accuracy in Patients Referred for Myasthenic Ptosis

Maria Pia Giannoccaro (Bologna, Italy) and Rocco Liguori (Bologna, Italy)

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We thank Dr. Silvestri for the comment on our article1 and agree that a relatively high proportion of patients showed discordant results between the ice pack test and single-fiber electromyography (SF-EMG) because they were observed in 15% of patients with a final diagnosis of ocular myasthenia (OM). Most of discordant cases were related to the negativity of the ice pack test in the presence of an altered SF-EMG result. One explanation could be the lack of repetition of the ice pack test, as we outlined in the discussion. Indeed, a previous study showed that repeated ice pack tests improved sensitivity by 34.6% compared with a single test.2

We also found that the repetition of the ice pack test in some patients increased its sensitivity and, therefore, the number of patients showing concordant results (unpublished data).

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We also acknowledged that we did not investigate the usefulness of the ice pack test in patients with isolated diplopia. Nevertheless, Chatzistefanou et al. reported a sensitivity of 76.9% and a specificity of 98.3%, suggesting that the ice pack test is similarly useful in the assessment of myasthenic diplopia. This could be particularly relevant because we showed that diagnostic tests for OM—including SF-EMG—are frequently negative in patients with this clinical presentation.


CORRECTIONS

Lesion Evolution and Neurodegeneration in RVCL-S
A Monogenic Microvasculopathy
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In the article “Lesion Evolution and Neurodegeneration in RVCL-S: A Monogenic Microvasculopathy” by Ford et al., the following sentence was omitted from the Study Funding statement: “This work was supported by Clayco Foundation, Energy 4A Cure Foundation, Cure CRV Research and The Foundation for Barnes Jewish Hospital (MB, MKL, DH, JMJ, JPA).” The authors regret the omission.

Reference

Apathy and Risk of Probable Incident Dementia Among Community-Dwelling Older Adults
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In the article “Apathy and Risk of Probable Incident Dementia Among Community-Dwelling Older Adults” by Bock et al., the Study Funding should read: “This research was supported by National Institute on Aging (NIA) Contracts N01-AG-6-2101; N01-AG-6-2103; N01-AG-6-2106; NIA grant R01-AG028050, and NINR grant R01-NR012459. This research was funded in part by the Intramural Research Program of the NIH, National Institute on Aging. It is also supported through NIA K24 AG-31155.” The authors regret the omission.

Reference
Lesion Evolution and Neurodegeneration in RVCL-S: A Monogenic Microvasculopathy

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