Welcome to the New WORLD NEUROLOGY!

Starting with this issue, WORLD NEUROLOGY will have new content and a new look. As the newsletter of the World Federation of Neurology (WFN), WORLD NEUROLOGY is the only publication going to all neurologists in the world.

The newsletter will continue to feature news from the WFN. However, the new version will have other content of interest to neurologists, including some neuroscience news, and will be published by Elsevier.

We are all grateful to Prof. Jagjit Chopra, who has done a spectacular job of editing WORLD NEUROLOGY for the past decade.

So who am I? I am a neurologist at the National Institute of Neurological Disorders and Stroke, at the National Institutes of Health in Bethesda, Md., where I do clinical research. My interests are clinical neurophysiology and movement disorders. I recently completed an 8-year term as editor in chief of Clinical Neurophysiology. Presently, I served as an associate editor for the journal Brain as well as for a new journal, Brain Stimulation. Although I hope to assemble an editorial board to help me in the coming months, as the new medical editor, I will be looking for input from everyone.

So please send in local news, or news of interesting medical and scientific advances. What interests you may well interest others.

In this inaugural issue, you will find some new features. One of these is "Profiles in Neurology." In it, I hope to spotlight different medical care practices from around the world, giving one neurologist his or her chance at "fifteen minutes of fame," as the expression goes. I am grateful to Dr. Rawiphan Witoompanich of Mahidol University, Bangkok (Thailand), for starring in the first of these.

We're also interested in news from the National Societies that make up the WFN. For example, the German Society just celebrated its 100th anniversary. In this issue, Dr. Günther Deuschl and his colleagues present a brief history of the society. We will highlight other national societies in upcoming issues.

This issue also includes the first "Neurologic Pearl." This column will give an in-depth view of a brief, little known topic of interest in clinical neurology. The first installment is on the Ramsay Hunt syndromes. Can you describe all four without cheating?

We also will publish cases. Some of these may be disorders that are seen only in certain parts of the world or that are more common in particular places. Others may be rare but important to keep in mind. So send in your suggestions!

We expect that cases, as well as the other articles, will be illustrated with photographs or other images—an interesting MRI, for example. And with all articles, we will want to have a photograph of you, too.

World Neurology should be a useful and educational newsletter. Send your feedback and ideas to worldneurology@elsevier.com.

Let’s keep each other informed and knowledgeable, so we can bring good neurologic practice to our patients and have some fun along the way.

Mark Hallett
Editor in Chief
World Neurology

Oral Agent for Form of Multiple Sclerosis Shows Promise

BY DOUG BRUNK
Elsevier Global Medical News

Patients with relapsing remitting multiple sclerosis who took daily oral laquinimod over a 36-week period achieved a 40% reduction in gadolinium-enhancing lesions compared with patients who took placebo, according to phase II trial results.

"Overall, the efficacy and safety profile emerging from this and from a previous phase II clinical trial, in combination with the oral route of administration, make laquinimod a promising therapeutic opportunity for patients with relapse remitting multiple sclerosis," reported the researchers, led by Dr. Giancarlo Comi of the institute of experimental neurology at the Vita-Salute San Raffaele University, Milan.

Developed by Teva Pharmaceutical Industries Ltd., laquinimod is an oral immunomodulatory drug that is believed to exert anti-inflammatory activity in the relapsing remitting form of MS by the Th1-Th2 shift.

To date, approved drugs for MS are all injectable and include glatiramer acetate, interferon-β, natalizumab, and mitoxantrone.

Prof. Alastair Compston, head of the department of Clinical Neurosciences at the University of Cambridge (England), who was unaffiliated with the study, told World Neurology in an interview, "This is a first step in the direction of identifying a therapy for use early in the course of multiple sclerosis which is convenient, safe, and effective. Whether oral laquinimod meets these characteristics remains to be seen."

In a study conducted at 51 centers in nine countries, Dr. Comi and his associates randomized 102 patients with relapsing remitting multiple sclerosis to placebo, 68 to laquinimod 0.6 mg daily, and 66 to laquinimod 0.6 mg daily for 36 weeks (Lancet 2008;372:2083-92).

Patients were aged 18-50 years and underwent brain MRI and clinical assessments 4 weeks before the study started, at baseline, and then every 4 weeks for 9 months. The researchers measured the number of gadolinium-enhancing (GdE) lesions at weeks 12, 16, 20, 24, 28, 32, and 36. The primary end point of the study was the mean cumulative number of GdE lesions per scan in the last four scans.

The researchers reported that patients in the laquinimod 0.6 mg daily group demonstrated a 40% reduction in the mean number of GdE lesions over the last four scans, compared with those in the placebo group (a mean of 2.6 vs 4.2, respectively). Patients in the laquinimod 0.3 mg daily group had a mean number of GdE lesions similar to the placebo group (3.9). The latter finding surprised the researchers, considering that the 0.3-mg dose demonstrated efficacy, compared with placebo, in a previous study (Neurology 2005;64:987-91).

One possible explanation could be that the previous study used a triple dose of gadolinium, which increases the harvest of active multiple sclerosis lesions by 60%, and, as a consequence, increases the statistical power of MRI-monitored trials, "the researchers explain. See Multiple Sclerosis • page 2
New Editor in Chief
Mark Hallett Takes Over

The process of reforming World Neurology is over, and the inaugural issue, which you now hold in your hand, is the next link that will connect neurologists all over the world. Until the Chinese Society of Neurology joined the World Federation of Neurology last year, we served a membership of about 25,000. That number is now considerably higher, and I am proud to say that the World Federation of Neurology has become a global organization with members in 110 countries, in which more than 50 different languages are spoken.

The function of the newsletter, World Neurology, is to conduct news and to inform the regional neurology communities. Moreover, the newsletter also aims to be a medium through which the individual neurologist can stay in contact with colleagues around the world. World Neurology will serve as a support mechanism to a sense of solidarity, of knowing what is going on in neurology everywhere. Therefore, World Neurology will provide information about recent developments in modern neurology, with dissemination of therapeutic advances and discussions on hot topics in the neurologic community.

We are delighted to have Mark Hallett as our new editor in chief. Because he was the chair of the finance committee until he took over his new position, Mark Hallett knows the World Federation of Neurology very well. Dr. Hallett did his neurology training at Massachusetts General Hospital, Boston, and has a broad background in neurology and clinical neurophysiology. He currently serves as the chief of the Medical Neurology Branch of the U.S. National Institutes of Health, and chief of its Human Motor Control Section.

Dr. Hallett has also been the president of the Movement Disorder Society and vice president of the American Academy of Neurology. In conclusion, it is a real honor for the World Federation of Neurology to have Mark Hallett as the editor in chief of our international newsletter, especially at this crucial time when our organization is expanding and coming to new crossings.

The nominees are recommended to the membership through their representatives on the Council of Delegates, in accordance with the Federation’s Memorandum and Articles of Association. It is open to anyone to make additional nominations by securing the supporting signatures of five or more authorized delegates and submitting the name(s) of the individual(s) in question to the following address: Secretary, Treasurer General, c/o the London Secretariat Office, 12 Chandos St., London, WC1 9DR, United Kingdom. Nominations must be received by September 22, 2008. Recommended candidates:

- Prof. Nathan Bornstein (Israel)
- Dr. Antonio Culebras (Spain/USA)
- Dr. Gustavo Roman (Colombia/USA)
- Dr. Stephen Seregay (UK)

WFN Committee Has Named Candidates for Trustee Post

The following candidates are recommended by the Nominating Committee of the World Federation of Neurology for the Elected Trustee position, which is falling vacant in 2008 as Prof. Marianne de Visser, from the Netherlands, retires. The nominees are recommended to the membership through their representatives on the Council of Delegates, in accordance with the Federation’s Memorandum and Articles of Association.

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THE PRESIDENT’S COLUMN

WFN and Regional Neurologic Groups Share a Close Link

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he World Federation of Neurology (WFN) is one of the neurologist’s member organizations, membership to which is obtained through his or her national neurologic association. However, most neurologists also are usually members of local, regional professional organizations. An Indian neurologist, for example, might be a member of the Indian Academy of Neurology, the Asian Oceanian Association of Neurology (AOAN), and the World Federation of Neurology. A Norwegian neurologist, on the other hand, might be a member of the Norwegian Neurologic Association, the European Federation of Neurological Sciences (EFNS), and the World Federation of Neurology.

The regional neurologic associations, including the American Academy of Neurology, the AOAN, the EFNS, the Latin American Neurological Association, the Pan African Association of Neurological Sciences, and the Pan Arab Union of Neurological Sciences, are strong and independent organizations. They organize annual or biennial regional congresses. The presidents of the regional associations are ex officio WFN regional directors and have the possibility of closer contact with the corresponding regional World Health Organization offices in Brazzaville (Congo), Cairo (Egypt), Copenhagen, Manila, New Delhi, and Washington.

The World Federation of Neurology looks forward to closer contact with the regional neurologic organizations in part because of the coming geographic rotation of world congress venues.

The 2009 World Congress of Neurology, as you likely know, is set for Bangkok, in Thailand. The 2011 Congress will take place on the African continent. In 2013, the World Congress of Neurology is scheduled to be held somewhere in Europe, and in 2015, in Latin America.

There are two bids for the 2011 Congress. One possible venue is Cape Town, South Africa. The other is Marrakesh, Morocco.

‘WE LOOK FORWARD TO CLOSER CONTACT WITH THE REGIONS AND TO FUTURE EXCHANGE PROGRAMS.’

Both are extremely fascinating and attractive cities. The ultimate decision of congress venue will be made at the Council of Delegates Meeting in New Delhi in October, 2008.

As I mentioned, the World Congress of Neurology in 2013 will take place in Europe. The European Federation of Neurological Sciences, which up to now has organized successful annual regional congresses, has decided that the World Congress that year will also serve as an EFNS congress; there will be no independent EFNS meeting in 2013. The venue for that joint meeting has not yet been chosen; the EFNS will have the strongest voice in that decision, and we will let our members know.

The ultimate goal is to increase the visibility of the global responsibilities of the World Federation of Neurology. We look forward to closer contact with the regions and to future exchange programs for neurologists from different parts of the world.

World Neurology Foundation Launches New Web Site

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t is my pleasure as webmaster to announce the launch of the new Web site for the World Neurology Foundation. The Web site was released on April 27, 2008. For immediate access and to check out what’s new, please visit www.wfneurology.org.

The World Neurology Foundation was incorporated in 1999 as a charitable arm of the World Federation of Neurology. The new Web site will serve the organization internally by providing information about the mission, program, and meetings of the foundation to the organization’s staff, its 12-member volunteer board of directors, and the six-member advisory council.

The new Web site will also provide an essential external marketing function by engaging others in the foundation’s mission and projects, thus promoting financial support.

Users can expect the following highlights when accessing the new Web site:

► A home page that emphasizes the World Neurology Foundation’s central mission—to serve as a catalyst for the promotion of neurological care and education in countries in need—and neurological care purposes.

► An About Us section that contains content regarding mission, foundation overview, leadership, and staff profiles.

► A 2008 Projects feature, which describes the World Neurology Foundation’s projects, projects’ locations, overviews on project toolkits for Africa, Neuroshare, and 2008 lineup.

► Information about Partnership Programs, including lectureships, continuing medical education, and certification training.

► Opportunities for you to make donations that will go towards helping support various foundation projects, including the capacity to donate for use in specific programs.

► Congratulations to the World Neurology Foundation on this new Web site. Please don’t hesitate to direct any questions about the site to the World Neurology Foundation’s executive director, Carrie Becker, who can be reached at: checker@wfneurology.org.

Please Visit the Updated 2009 World Congress of Neurology Web Site

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he Web site for the official 19th World Congress of Neurology, to be hosted by the World Federation of Neurology, October 24–30, 2009, in Bangkok, Thailand, has now been updated. Information is now available regarding the preliminary program and general information about the Congress. The Web site will be updated continuously as the Congress approaches, so check back often as more is added.

Visit the Web site today at: www.wcn2009.bangkok.com, to see what’s new.

European Board Examination in Neurology Is Scheduled To Commence in 2009

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he European Union of Medical Specialists’ Section of Neurology and the European Board of Neurology will establish and administer a European board examination in neurology, beginning in 2009. This certification examination is part of a broader European effort to improve training in neurology.

To further assure the quality of neurology training, the UEMS/EBN has formed a committee to visit neurology departments throughout Europe. Residents of the centers that will receive a reduction in the examination fee.

The examination will consist of two parts. One will contain both written and multiple choice questions; the other will be an oral examination in which the candidates will answer structured questions about four specific cases.

Candidates can earn extra points by presenting either one of their own cases or results from scientific research done during their training.

Scientific panels from the European Neurological Society (ENS) and European Federation of Neurological Societies (EFNS) will collaborate to develop the examination. Scientific committees from the ENS and EFNS have teamed with the UEMS/EBN to form a joint European examination committee, which will have an advisory role to the UEMS/EBN.

The application for the examination will be available from the UEMS/EBN Web site (www.uems-neuroboard.org/ebn).

At the time of the implementation of the examination, only those candidates from EU/EEA (European Economic Area) countries and who have either passed their national examination or have confirmation from their national society that they are eligible can be admitted.

Because their practical skills will be confirmed by the candidates’ national training society, the examination will be a multi-step process.

Although many European countries have their own national training system, and the UEMS/EBN examination will have no legal power, it is hoped that countries without a system will adopt this examination as a standard.

The EBN examination is being developed as a measure of excellence, such as those already established by many other UEMS sections and boards.

The successful candidates will be awarded the title of Fellow of the European Board of Neurology.

In cooperation with the big European neurologic societies (EFNS and ENS), the UEMS/EBN will launch this important step in training in neurology.

For more information, visit the UEMS/EBN Web site at www.uems-neuroboard.org or e-mail the VMA office in Vienna: manuel.hoetzendorfer@medacad.org.

By Prof. Wolfgang Grisold, who is chair of the education committee at the EFNS and president of the EBN and Prof. Svend Mellgren, who is the EBN chair. 
Meeting Report: WFN Junior Traveling Fellowship 2008

From Shanghai to Chicago, the WFN supports its members around the globe.

Editor’s Note:
This year, Dr. Xiang-Jun Chen was one of several young neurologists to receive a World Federation of Neurology (WFN) Junior Traveling Fellowship. He had to attend the 2008 annual meeting of the American Academy of Neurology in Chicago. To me, attending the American Academy of Neurology (AAN) annual meeting is always an excellent way to refresh and update my knowledge of clinical neurology. However, as a young neurologist now living in Shanghai, the expense of traveling to the United States to attend this meeting was intimidating. Fortunately, the generous gift of a Junior Traveling Fellowship from the World Federation of Neurology made it possible for me to attend.

The AAN annual meeting is an event in the field of neurogenetics at the University of Chicago and began my long pursuited career in academic neurology as a faculty member in the neurology department at Fudan University Huashan Hospital (Shanghai, China). To me, attending the American Academy of Neurology (AAN) annual meeting is always an excellent way to refresh and update my knowledge and clinical neurology. However, as a young neurologist now living in Shanghai, the expense of traveling to the United States to attend this meeting was intimidating. Fortunately, the generous gift of a Junior Traveling Fellowship made it possible for me to attend. The AAN annual meeting is in the broad spectrum of cognitive impairment caused by or associated with cerebrovascular disease and Alzheimer’s disease. This event was most attractive to me because I have been working on a genetic neuropathy mouse model with a defect of mitochondrial transport. During this session, I met many of my neurologist peers involved in neuroscience research and exchanged scientific views. Points with them in our fields of common interest. Through the introduction of Dr. Raymond Roos, head of the department, plus an abstract if a paper or poster is to be presented. Applications must state the names and dates of the proposed meeting they wish to attend, send a resume, bibliography, and an estimate of expenses, to a maximum of £1,000; and enclose a letter of recommendation from the head of the department, plus an abstract if a paper or poster is to be presented. Awards are assessed by the Executive Committee of the WFN’s Education Committee.

Nominations for the 2009 fellowships are not yet being considered. Check WORLD NEUROLOGY for updates when applications will be accepted.

VLADIMIR HACHINSKI Is a Leader of Many Accomplishments

Since Dr. Vladimir Hachinski, professor of neurology and Distinguished University Professor at the University of Western Ontario, London, was elected first vice president of the WFN, he has developed some impressive work for the WFN. But Dr. Hachinski has long been one of the most prestigious members in the field of neurology.

Born in Europe and raised in Latin America, Dr. Hachinski received his MD from the University of Toronto in 1960. After his residency there, he was a fellow at the National Hospital for Nervous Diseases at Queen Square, London (England), and the University of Copenhagen. After his initial return to the University of Toronto in the early 1970s, he joined the faculty at Western Ontario in 1980. With John Norris, he established the first diagnostic and research unit for the urgent care and systematic study of patients with “brain attack.” He codiscovered the Toronto Stroke Scale with John Norris, and discovered the role of the right insula of the brain in mediating cardiac complications of stroke, including sudden death.

Dr. Hachinski proposed the concept of “multi-infarct dementia” and later that of “vascular cognitive impairment” to encompass the broad spectrum of cognitive impairment caused by or associated with vascular factors. He developed the Hachinski Ischemic Score (2,100 citations) to identify the vascular component of cognitive impairment, and led, along with Gabrielle Leblanc, a group of experts in developing common standards for describing and studying cognitive disorders. He also helped develop a model to study the interaction between cerebrovascular disease and Alzheimer’s disease.

Dr. Hachinski has also published 17 books and more than 600 scientific papers, book chapters, editorials, and other works. As editor in chief of Stroke, he initiated its translation into Spanish, Russian, Italian, Portuguese, Chinese, Japanese, and Korean, and a special edition for readers in India. He also started the Author Mentoring Program, through which he welcomes manuscripts from contributors in the country. For the editor’s request, will assign a member of the editorial board. He arranged free subscriptions for readers in select countries.

In 2004, Dr. Hachinski led a working group that resulted in the establishment of World Stroke Day (Oct. 29) and the development of a world stroke agenda. Dr. Hachinski received an ScD from the University of London (England), and three doctor honors causa from the universities of Salamanca, Buenos Aires, and Cordoba, respectively. He was the first recipient of the Trillium Award, which is given to the best clinical researcher in the province of Ontario, and he also received the international Mihara Award, given every 4 years to someone who has made major contributions to the field of stroke.

As Canada’s delegate to the WFN and chairman of its steering committee for two terms, Dr. Hachinski was presented with a diploma whose citation reads in part, “Brought parity and fairness in the international Mihara Award, given every 4 years to someone who has made major contributions to the field of stroke.” As first vice president, he initiated the process that led to the decision to hold a world congress every 2 years in a different part of the world—the premise being that such meetings have the greatest impact in the region in which they are held, and that we need to reach neurologists or potential neurologists who cannot travel internationally. The greater frequency of meetings also allows a platform for increased activities in the years between them.

Dr. Hachinski is currently fostering cooperation between the WFN and other international organizations, specifically a collaboration with the International Brain Research Organization (IBRO). He is encouraging a survey of the membership, particularly of national delegates, to identify how the WFN can better serve them. As first vice president, he initiated the process that led to the decision to hold a world congress every 2 years in a different part of the world—the premise being that such meetings have the greatest impact in the region in which they are held, and that we need to reach neurologists or potential neurologists who cannot travel internationally. The greater frequency of meetings also allows a platform for increased activities in the years between them.

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Dr. Hachinski Named to Order of Canada

Dr. Vladimir Hachinski has recently been named to the Order of Canada, the country’s highest honor, for his lifetime contributions in neurology. The award was announced just as WORLD NEUROLOGY went to press.

“When I learned that the government was trying to track me down, I was in China and a few unpleasant possibilities crossed my mind,” joked Dr. Hachinski. “When I was informed that I was to be named to the Order of Canada, I was surprised, and felt honored and humbled to join such a distinguished company of Canadians,” he commented. The Order of Canada recognizes a lifetime of outstanding achievement, dedication to the community, and service to the country.
Drug development is under way to treat Parkinson’s disease with gene therapy. An alternative to both is surgery.

Pharmacologic therapy is the mainstay of the symptomatic treatment of Parkinson’s disease; deep brain stimulation is reserved for those with complications. An alternative to both may be gene therapy.

Gene therapy works by inserting a normal gene into a nontarget location within the genome in order to replace a nonfunctional gene or to establish a new function or role for the cell. Release of the gene product then acts on the affected or neighboring cells. The approach has advantages. Depleted neurotransmitters can be replaced in a more physiologic manner so that certain complications are less likely. Therapies can be delivered in a site-specific way, so that other side effects (like the mental side effects of dopaminergic drugs) are avoided. One treatment may provide sustained benefit. And unlike DBS, there are no device complications.

Gene therapies have been studied in animal models of parkinsonism for the last 20 years, but only in the last 5 years have clinical studies been undertaken in humans. The usual vector for gene delivery to the target cells is adenovirus type 2 (AAV2). This virus is not associated with human disease, can infect nondividing human cells, shows low immunogenicity, and is not associated with oncogenesis. Most humans have been infected naturally, but the mode of infection is unclear. The virus, when injected into the striatum, is taken up selectively by neurons.

Gene therapy by transfec-
tion of the subthalamic nucleus (STN) with AAV containing the gene for glutamic acid decarboxylase (GAD) leads to synthesis of the inhibitory neurotransmitter γ-aminobutyric acid. This reduces STN output and hence its inhibitory effect on the thalamus. The rationale is thus similar to treatment by DBS of the subthalamic nucleus, but the gene therapy avoids hardware-based complications, programming and maintenance.

In an open-label safety study, 12 patients with advanced PD received unilateral infusion of AAV-GAD into the subthalamic nucleus (four patients each in three dose cohorts). Patients were assessed clinically and by PET imaging (Lancet 2007;369:2097). There were significant improvements in motor Unified Parkinson Disease Rating Scale scores contralateral to surgery at 3 months. These persisted to 12 months; fluorodeoxyglucose–positron-emission tomography (FDG-PET) showed reduction in thalamic metabolism on the treated side at 1 year, similar to after DBS. No adverse effects were related directly to gene therapy.

An alternative approach involves the gene for aromatic l-amino acid decarboxylase (AADC), which converts levodopa to dopamine. As PD advances, many patients require increasingly more levodopa to maintain benefit. In a phase I study, 10 patients with moderately advanced PD and response fluctuations received either a low or high dose of AAV-AADC into the postcomissural putamen bilaterally (Neurology 2008;70:1980-3). Patients were assessed clinically and by PET imaging with fluorodopa to maintain benefit. In a phase I study, 10 patients with stage III or IV PD and response fluctuations (Lancet Neurol. 2008;7:400-8). There were no major adverse events, and significant clinical improvement was seen, compared with baseline.

These results suggest that gene therapy simply to duplicate what can already be achieved by a standard op-
eration?

Dr. Asnacios is director of the Parkinson’s Disease Clinic and Research Center and the executive vice chair of the Department of Neurology at the University of California, San Francisco.
Living beyond 2 years was significantly more likely for patients on radiotherapy plus PCV.

**By KERRI WACHTER**

Elsevier Global Medical News

CHICAGO — Progression-free survival begins to improve after 2 years when patients with high-risk, low-grade gliomas are treated with chemotherapy and radiation rather than with radiation alone, according to the results of a phase III trial.

Progression-free survival rates were similar at 2 years, whether patients were treated with radiation alone or with radiation plus a chemotherapy regimen of procarbazine/lomustine/vincristine (PCV)—plus a chemotherapy regimen of procarbazine/lomustine/vincristine (PCV)—compared with radiation alone or with radiation plus a chemotherapy regimen of procarbazine/lomustine/vincristine (PCV)—74% and 75%, respectively.

The groups began to separate after 2 years, however. Progression-free survival at 5 years was 46% for the radiotherapy arm and 63% for the combination arm (hazard ratio 0.60, P = .06).

Overall survival showed a similar trend. Two-year overall survival was comparable for the two groups (85%-87%), but at 5 years, overall survival was 63% for the radiotherapy arm and 72% for the combination arm (HR 0.72, P = .33), Dr. Edward Shaw, who is the senior investigator in the Radiation Therapy Oncology Group (RTOG) protocol 9802 study for high-risk patients who had newly diagnosed adult supratentorial low-grade gliomas (World Health Organization grade II) and a Karnofsky performance score of at least 60. High risk was defined as either being at least 40 years of age or being a patient of any age with an incomplete resection/biopsy. Results for low-risk patients were previously reported.

A total of 251 patients were randomized either to radiation therapy alone (126 patients) or to radiation plus six 8-week cycles of chemotherapy (125 patients). Radiation was given to localized treatment fields and consisted of 30 1.8-Gy fractions (54 Gy total). Postradiation chemotherapy consisted of 60 mg/m² oral procarbazine (Matulane) on days 8-21, 110 mg/m² oral lomustine (CeeNU) on day 1, and 1.4 mg/m² IV vincristine on days 8 and 29 (no greater than 2 g per dose).

Median follow-up was 6 years. Median progression-free survival for the radiotherapy group was 4.4 years, but has not been reached for the combination arm. Likewise, median overall survival for patients in the radiation therapy arm was 7.5 years; median overall survival has not yet been reached by patients in the combination arm. Patients who survived beyond 2 years tended to be younger (less than 40 years), to have undergone resection (versus biopsy), and to have oligodendrogliomas/oligoastrocytomas, said Dr. Shaw, who is chair of the radiation oncology department at Wake Forest University, Winston-Salem, N.C.

Psoriasis Independently Increases Stroke Risk

**By BRUCE JANCIN**

Elsevier Global Medical News

KYOTO, JAPAN — Severe psoriasis appears to be a potent risk factor for stroke independent of the traditional stroke risk factors, Dr. Rahat S. Azfar said at an international investigative dermatology meeting. Dr. Azfar presented a case-control study drawn from the U.K. General Practice Research Database (GPRD) in which she found that severe psoriasis was associated with an excess stroke risk amounting to one additional stroke per 130 patients per year, beyond background levels of traditional stroke risk factors.

“The prevalence of psoriasis worldwide, these numbers carry a potentially significant impact on public health,” observed Dr. Azfar, of the University of Pennsylvania, Philadelphia.

Psoriasis affects roughly 2.5% of the population worldwide, including an estimated 4.5 million U.S. adults. Five percent of psoriasis patients have severe disease as defined by a need for systemic therapy or phototherapy. Dr. Azfar and her coinvestigators had previously shown psoriasis to be an independent risk factor for acute MI, also using the GPRD. But the relationship between psoriasis and stroke had never before been studied.

The GPRD is an extensive electronic medical record including more than 9 million U.K. patients under the care of general practitioners/family physicians in 450 primary care practices. Dr. Azfar reported on 129,143 patients with mild psoriasis in 1987-2002 and 496,668 contemporaneous controls without psoriasis, along with 3,603 patients with severe psoriasis and 14,330 separate controls. The mean follow-up was about 4 years. As found in other studies, patients with severe psoriasis had higher rates of obesity and smoking than did controls, while rates of these and other traditional cardiovascular risk factors were similar in patients with mild psoriasis and in controls.

After adjustment for the major stroke risk factors—diabetes, hyperlipidemia, smoking, obesity, hypertension, age, and gender—patients with mild psoriasis were found to have a statistically significant 5%-per-year increased relative risk of stroke.

In contrast, the stroke risk in patients with severe psoriasis was increased by 43% per year, compared with matched controls.

The attributable risk of stroke in patients with mild psoriasis was 2.4 strokes per 10,000 person-years, and with severe psoriasis it was 1.9 strokes per 1,000 person-years.

A caveat: Data audit suggested up to 15% of patients categorized in the GPRD as having mild psoriasis may actually have had moderate disease.

If so, truly mild psoriasis may not be associated with any significant excess in strokes, according to Dr. Azfar.

The working hypothesis is that the link between psoriasis and stroke—and MI as well—inherits from T1/T17-mediated systemic inflammation, a prominent shared feature, she explained at the meeting, sponsored by the European Society for Dermatological Research, the Japanese Society for Investigative Dermatology, and the Society for Investigative Dermatology.

“The researchers also performed a conditional probability analysis for overall survival, asking what the likelihood of living longer than 2 years was for those patients who had lived to 3 years. ‘The likelihood of living beyond 2 years was significantly better for patients who were treated with radiotherapy plus PCV versus radiation therapy alone (HR 0.52, P = .03),’ said Dr. Shaw.

A similar analysis for progression-free survival resulted in an even more pronounced advantage to those on combination therapy (HR 0.44, P = .002).

Severe toxicity (grade 3/4) was more common for the combination arm. Grade 3 toxicities occurred in 8% of patients in the radiotherapy arm, compared with 15% in the combination arm. Likewise, grade 4 toxicities occurred in 3% of patients in the radiotherapy arm, compared with 15% in the combination arm. “Most of the toxicities were hematologic and reversible,” said Dr. Shaw.

Dr. Shaw reported that he had no conflicts of interest.

Psoriasis Independently Increases Stroke Risk

**By MR. DANIEL B. SHIN**

Elsevier Global Medical News

DARTMOUTH, N.H. —Psoriasis independently increases the stroke risk for the two groups (85%-87%), but at 5 years, overall survival was 63% for the radiotherapy arm and 72% for the combination arm (HR 0.72, P = .33), Dr. Edward Shaw, who is the senior investigator in the Radiation Therapy Oncology Group (RTOG) protocol 9802 study for high-risk patients who had newly diagnosed adult supratentorial low-grade gliomas (World Health Organization grade II) and a Karnofsky performance score of at least 60. High risk was defined as either being at least 40 years of age or being a patient of any age with an incomplete resection/biopsy. Results for low-risk patients were previously reported.

A total of 251 patients were randomized either to radiation therapy alone (126 patients) or to radiation plus six 8-week cycles of chemotherapy (125 patients). Radiation was given to localized treatment fields and consisted of 30 1.8-Gy fractions (54 Gy total). Postradiation chemotherapy consisted of 60 mg/m² oral procarbazine (Matulane) on days 8-21, 110 mg/m² oral lomustine (CeeNU) on day 1, and 1.4 mg/m² IV vincristine on days 8 and 29 (no greater than 2 g per dose).

Median follow-up was 6 years. Median progression-free survival for the radiotherapy group was 4.4 years, but has not been reached for the combination arm. Likewise, median overall survival for patients in the radiation therapy arm was 7.5 years; median overall survival has not yet been reached by patients in the combination arm. Patients who survived beyond 2 years tended to be younger (less than 40 years), to have undergone resection (versus biopsy), and to have oligodendrogliomas/oligoastrocytomas, said Dr. Shaw, who is chair of the radiation oncology department at Wake Forest University, Winston-Salem, N.C.

The working hypothesis is that the link between psoriasis and stroke—and MI as well—inherits from T1/T17-mediated systemic inflammation, a prominent shared feature, she explained at the meeting, sponsored by the European Society for Dermatological Research, the Japanese Society for Investigative Dermatology, and the Society for Investigative Dermatology.

To examine the possibility that the excess stroke risk seen in severe psoriasis was a function of toxicities of treatments for the disease rather than being intrinsic to severe psoriasis itself, the investigators reanalyzed the data after excluding methotrexate users or restricting the analysis to patients treated with oral retinoids. It didn’t have any significant impact upon the results. Neither did exclusion of psoriatic arthritic patients.

A German dermatologist in the audience questioned the reliability of psoriasis diagnoses in the GPRD. In his country, he added, general practitioners get it wrong at least 30% of the time. Dr. Azfar replied that she and her colleagues had excluded methotrexate users or restricting the analysis to patients treated with oral retinoids. Dr. Azfar replied that she and her colleagues had excluded methotrexate users or restricting the analysis to patients treated with oral retinoids. In her country, she added, general practitioners get it wrong at least 30% of the time.

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German Society for Neurology Celebrates 100th Anniversary

BY DR. STEFAN BRANDT, DR. GÜNTHER DEUSCHL, AND DR. AXEL KARENBERG

Editor’s note: As the German Society for Neurology celebrates its 100th year, we present a look back. The Founding Years

“We call ourselves neurologists (Nervenärzte) and are proud to declare ourselves representatives of this science. We are united by our love of the profession." When Hermann Oppenheim spoke these words on Sept. 14, 1907, to open the first meeting of the Association of German Neurologists (Gesellschaft Deutscher Nervenärzte), the discipline had already looked back on a long tradition. In 1840 Moritz H. Romberg published the world’s first textbook that described all of the disorders of the nervous system that were then known.

In subsequent decades, physicians interested in neurology produced impressive research results. In 1874, Carl Wernicke described sensory aphasia and in 1884, Wilhelm Erb discussed muscular dystrophy. In 1891, Heinrich Quincke reported the first successful spinal tap; in 1906, Alois Alzheimer published a case of presenile dementia.

Shortly before World War I, Max Nonne in Hamburg and Rudolf Forster in Breslau set up independent departments. In contrast to those in France, Great Britain, and the United States, German medical schools and community hospitals long considered clinical neurology a subdiscipline of psychiatry or internal medicine.

During the first quarter-century, membership of the Association of German Neurologists grew quickly, to 720. Many scientific papers from international authors were published in German. The main topics of the annual meetings between 1916 and 1930 reflected the questions of the day: shell shock (Kriegszezter), brain trauma, neurosyphilis, epilepsy, and new diagnostic methods. It was in this period that Hans Berger described the EEG, implementation of which in clinical practice was an international scientific achievement.

The Dark Years

The advent of Nazism in 1933 had a dramatic effect on scientific leadership, morality, the quality of clinical care, and the science of German neurology. For Jewish neuroscientists, this was the beginning of the distressing history of expulsion from the profession. Some were deported to concentration camps or chose suicide. The long list of emigrants reads like a who’s who of Central European neurology: Josef Gerstenmann, Kurt Goldstein, Sir Ludwig Guttmann, Friedrich Heinrich Lewy, Adolf Wallenberg, and Robert Wartenberg.

Because the Third Reich sought to stop or even reverse medical specialization, the neurologic association was forcibly “reunited” with psychiatry in 1935, a step that thwarted any further aspirations of autonomy.

More appalling was the involvement of German brain researchers, neuropathologists, and neurologists in the ideologically guilty of crimes against humanity. The hospitals were destroyed, and our international reputation in the field had been lost. With Germany divided after the war, the Cold War limited contact between neurologists on the two sides of the country. In West Germany, neurologists were rechristened in 1950 as the German Society for Neurology (DGNeuroArzt). In East Germany, the legal successor to Gesellschaft Deutscher Nervenärzte was the reconstituted Society for Psychiatry and Neurology, in which neurologists and psychiatrists remained in the same organization.

The challenge is to maintain high standards of care for the increasing number of neurologic patients, despite budget cuts for medical care in Germany. The future development of neurology and neurologic care will depend on the success of research to cure or postpone the handi cap of neurologic disease. This task is an international one, and the DGN is open for international collaboration.

Dr. Brandt is the chairman of the department of neurology at Humboldt University Berlin.

Editor’s note: As the German Society for Neurology celebrates its 100th year, we present a look back. The Founding Years

“The most important event of the second half of the last century for the country as well as the DGN was the reunification of Germany in 1989. The DGN today has almost 6,000 members and holds annual congresses. In 2007, more than 5,000 people came to the Anniversary Congress in Berlin. Our meetings are combined with those of a national Academy of Neurology and cover all aspects of the specialty. The DGN is engaged in setting the standards for neurologic care. It has developed and updated guidelines for therapy and diagnosis of many neurologic diseases.

During recent years, the DGN changed its internal structure and now is organized as a contemporary society with its permanent professional headquarters in Berlin. Our future challenge is to maintain high standards of care for the increasing number of neurologic patients, despite budget cuts for medical care in Germany. The future development of neurology and neurologic care will depend on the success of research to cure or postpone the handicap of neurologic disease. This task is an international one, and the DGN is open for international collaboration.

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Dr. Brandt is the chairman of the department of neurology at Christian-Albrechts University, Kiel (Germany), and also is president of the German Society for Neurology. Dr. Deuschl is the editor of the Institute for the History of Medicine and Medical Ethics at the University of Cologne (Germany).
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E: secretariat@pactrims2008.org

Deadline of paper submission
1 October 2008

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15 October 2008
BY ALEX TSELSIS, M.D., PH.D.

Dengue fever (DF) is an acute febrile illness found in tropical and subtropical parts of the world. It is caused by a mosquito-borne flavivirus, and characterized by high fevers, headaches, rash, and joint pains. So why does it concern neurologists?

In years past, DF resembled severe influenza, in which prostration was thought to be part and parcel of the general toxic effect. Physicians now realize that many patients are frankly encephalopathic, which raised the question: Does the virus invade the brain and cause encephalitis? Dr. R.B. Domingues and colleagues evaluated 45 consecutive adults with dengue fever during the 2002-2003 summer season dengue epidemic in Brazil. They found 18 (21%) with prominent neurologic complications. It is also not known whether a direct viral infection of neurons occurs or if there is an immunopathogenetic mechanism, such as acute parainfectious demyelination.

Contacted by World Neurology, Dr. Domingues of the department of pathology at the Escola Superior de Ciências da Saúde de Vitória (EMESCAM), Vitória (Brazil), noted, “Dengue virus infection is a very common disease in the developing world.”

“In 2008, there were more than 120,000 dengue cases registered in Brazil, with more than 600 cases of dengue hemorrhagic fever and almost 10 deaths. Considering the fact that, during epidemics, many cases of patients with neurological involvement are expected to be seen, neurologists must be familiar with the potential neurological manifestations.”

Dr. Tselsis is an associate professor of neurology at Wayne State University, Detroit.
He is the Reviews and Book Reviews Editor for the Journal of the Neurological Sciences.

New Study Will Combat Stigma of Epilepsy in Zambia

BY DENISE NAPOLI

Dr. Gretchen Birbeck first became aware of the pervasive stigma experienced by Zambians with epilepsy in 1994, while working in a clinic in the small, southern African country. People with epilepsy would come in for treatment all the time—for a burn or another injury experienced during a seizure—but not for the disease itself. Having epilepsy was not something to be publicized, even to health care professionals.

Many epilepsy patients around the globe complain of stigma associated with the disease. In the western world, “Data...strongly suggest that the stigma people with epilepsy have is often self-inflicted. They have life limitations that they’ve often self-imposed,” said Dr. Birbeck. But in Zambia, the limitations experienced by epileptics are especially dramatic. And very real.

For example, “People with epilepsy are very disadvantaged in education and employment but also in terms of marriage,” said Dr. Birbeck. It’s difficult to find a partner, but perhaps even more troubling is that even after marriage, “the women, especially, were abandoned.” Findings from an observational study conducted by Dr. Birbeck and her colleagues from 2003-2007 revealed that single women with epilepsy felt vulnerable to sexual assault, which prevented them from seeking health care—and not unduly (Lancet Neurol. 2007;6:39-44). “When we did our quantitative assessment, the rate for rape when epilepsy was 20%, compared to less than 3% in our comparison group.”

There is even evidence of discrimination against epileptic children by their own parents. In a comparison of epileptic children’s food intake and nonaffected children’s rations across households of similar means, “relative to the child in the other household, the child in the household with epilepsy had food deprivation,” said Dr. Birbeck, associate professor and director of the International Neurologic and Psychiatric Epidemiology program at Michigan State University.

Now Dr. Birbeck and her colleagues from Michigan State, the University of Zambia, and several Zambian health care institutions will have an opportunity to affect some of that stigma faced by Zambians with epilepsy in 1994, as part of their ongoing intervention program, where the teachers will learn about the disease from an educator they have never met. At week’s end, “the teachers will find out that this person they’ve been working with all week actually has epilepsy,” she said. “They will develop a bond with the educator, perhaps more than the lessons themselves, will break the teachers of discriminatory habits.”

Another example involves Zambia’s traditional healers. Dr. Birbeck’s previous research showed that one of the factors in their discrimination against epilepsy patients is whether they believe the disease is medical or the result of witchcraft. She hopes to teach healers the scientific causes of epilepsy.

Intervention in households, however, will be more difficult, and will not be a focus of the present study. According to Dr. Birbeck, after her last study, “I don’t think we understand that dynamic well enough to know.”

For example, she said, sometimes it is not uncommon for parents of children with epilepsy to elect not to send their child to school. “Sometimes it’s because they don’t want to waste money” on a child who, they presume, won’t amount to much.

But “sometimes it’s because they’re worried the child isn’t safe at school.” In both cases, the child loses, but they are “very different motivating factors. We need to understand that better, so we can intervene,” said Dr. Birbeck.

Her upcoming study will be funded with a $1.38 million grant from the National Institute of Neurological Disorders and Stroke of the National Institutes of Health.
NEUROLOGIC PEARL

The Ramsay Hunt Syndromes

BY MARK HALLETT, M.D.
Editor in Chief

For reasons that are not always clear, sometimes people’s names get attached to neurologic syndromes. One of the champions in this regard is James Ramsay Hunt, who has at least four syndromes named after him. Perhaps he gained this recognition because of the superb detail of both his clinical reports and correlative pathological studies.

The four Ramsay Hunt syndromes are sufficiently confusing that they are now designated by type.

Hopefully, the following list will help keep these often-perplexing syndromes straight.

▶ Ramsay Hunt syndrome I is a progressive hereditary neurodegenerative disease characterized by ataxia, myoclonus, seizures, and cognitive decline.

Dr. Hunt believed that he was describing cases before him by Unverricht and Lundborg, but some people started using Dr. Hunt’s name to describe patients with these symptoms. The use of Ramsay Hunt syndrome to describe this disorder is confusing since there are so many etiologies for this syndrome (Hunt JR. Dysynknergia cerebellaris myoclonica—primary atrophy of the dentate system. A contribution to the pathology and symptomatology of the cerebellum. [Brain 1921;44:490-538]).

▶ Ramsay Hunt syndrome II, also called Herpes zoster oticus, is a herpes zoster infection of the geniculate ganglion with pain in the ear, herpetic blisters of the skin of the ear canal or auricle, and facial paralysis. This was an original description, and it is called type II even though its description preceded that of type I by 14 years (Hunt JR. On herpetic inflammation of the geniculate ganglion: a new syndrome and its complications. [J Nerv Ment. Dis. 1907;34:73-96]).

▶ Ramsay Hunt syndrome type III can be described as a compression neuropathy of the deep palmar branch of the ulnar nerve from an occupational cause (Hunt JR. Occupational neuritis of the deep palmar branch of the ulnar nerve: a well-defined clinical type of professional palsy of the hand. [J Nerv Ment. Dis. 1908;35:673-89]).

Finally, Ramsay Hunt syndrome type IV, which is also called Ramsay Hunt paralysis, is a form of juvenile Parkinson disease with the pathological substrate of neuronal degeneration in the globus pallidus. Juvenile Parkinson disease had been described, but at the time of this article there had not been any prior neuropathologic correlation (Hunt JR. Progressive atrophy of the globus pallidus [primary atrophy of the pallidal system]. A system disease of the paralysis agitans type, characterized by atrophy of the motor cells of the corpus striatum. A contribution to the functions of the corpus striatum. [Brain 1917;40:38-148]).

The Ramsay Hunt Syndromes

JULY 2008 • WWW.WFNEUROLOGY.ORG

WFN Now Accepting Nominations for Two New Medals

The Trustees of the World Federation of Neurology have decided to establish two new WFN medals, one for Service to Neurology and one for Achievement in Neurology.

Each award will carry a honorarium of $5,000. Nominations, which may be made either by World Federation of Neurology member societies or by individual members of a member society, should be seconded by at least five neurologists.

Three of these individuals should be from other WFN member societies.

The nominated individual should have approved the nomination and the principal proposer should write a citation of no more than 300 words in support of the nomination.

The Medal Committee will be made up of the current president of the WFN and two previous World Federation of Neurology presidents or of World Federation of Neurology trustees of the president’s choice.

The first medals will be awarded during the 2009 World Congress of Neurology in Bangkok (Thailand). All nominations should be sent to:

The Medal Committee
c/o the World Federation of Neurology London Office
12 Chandos St., London, W1G 9DR, United Kingdom

Nominations must arrive by October 10, 2008.

12th Asian Oceanian Congress on Neurology & 16th Annual Conference of the Indian Academy of Neurology

(AOCN-IANCON 2008)

Organized under the aegis of:
Asian Oceanian Association of Neurology (AOAN),
Indian Academy of Neurology (IAN),
World Federation of Neurology (WFN),
Delhi Neurological Association (DNA)

In association with
Association of Indian Neurologists in America (AINA)

Pre-Conference workshops on EEG,
Multiple Sclerosis, Movement Disorder & Advocacy
October 22, 2008 (Wednesday)

Main Conference
October 23-26, 2008 (Thursday-Sunday)

CME Accreditation
The 12th Asian Oceanian Congress of Neurology (AOCN 2008) & 16th Annual Conference of the Indian Academy of Neurology (IANCON 2008) have applied to Delhi Medical Council for accreditation of CME hours for the AOCN - IANCON Workshops and the Main Conference.
This issue’s column takes us to Bangkok, Thailand, and the practice of Dr. Nelly Chiofalo, who is a neurologist and associate professor and consultant neurologist in a medical school. Dr. Witoonpanich obtained her medical degree from Ramathibodi Hospital in Thailand, where she began her training. She had further training in England, where she worked at Newcastle General Hospital, St. Thomas’ Hospital, and the National Hospital for Neurology and Neurosurgery. Dr. Witoonpanich specializes in neurophysiology and has expertise in electromyography (EMG). Dr. Witoonpanich is also interested in neuromuscular disorders, particularly myasthenia gravis. She currently teaches at Mahidol University, Bangkok, and is on the faculty of medicine at Ramathibodi Hospital.

Dr. Chiofalo was born on April 18, 2008. Dr. Chiofalo was one of the pioneers in the development of clinical neurophysiology in Latin America. She was one of the pioneers in the development of the field in our region, have become less common nowadays because people are more aware of hygiene and health maintenance. Infections that we used to see quite often were pyogenic meningitis, viral meningoencephalitis, tuberculous meningitis, cryptococcal meningitis, neurocysticercosis, eosinophilic meningitis from Angiostrongylus cantonensis, eosinophilic meningoencephalitis caused by Gnathostoma spinigerum, and neurosyphilis. However, opportunistic infections such as tuberculosis, cryptococcosis, and toxoplasmosis are still prevalent among patients with AIDS.

There are also occasional outbreaks of food-borne botulism. The largest occurred 2 years ago and affected more than 100 people. The implicated food was improperly processed home-packed bamboo shoots.

There are opportunities to do clinical research here in Bangkok. Research is encouraged but not compulsory in our institution; however, academic positions and promotions depend on the amount of research completed, having a certain number of publications and book chapters. There is some limitation on advanced research because of a shortage of trained personnel and funding. I have one or two half-days a week spared for my research, which is mainly on myasthenia gravis, some muscle diseases, and the clinical application of EMG.

In the past, I have served as president of the Neurological Society of Thailand and organized a few international meetings, including the Asian and Oceanian Symposium on Clinical Neurophysiology in Bangkok in February 2003 and Chiang Mai, also in Thailand. I am a member of the executive committee of the Asian and Oceanian Myology Center and president of the Asian and Oceanian Chapter, as well as a member of the rule committee of the International Federation of Clinical Neurophysiology. The salary of a government officer is quite low here. Therefore, most doctors have to practice in the evening and over the weekend in private hospitals. This combination of hard work together with family commitment means there is not much time left for each individual to relax or exercise. I am no longer in private practice now and, as a result, I am able to spare 3 evenings a week for exercise, usually last- ing 2 hours at a time.

I devote most of my time to teaching and taking care of patients, with some hours spared for research. I insist on giving patients plenty of time so I can make an accurate clinical diagnosis, provide good care, and establish a good doctor-patient rapport. I enjoy my professional life and try to relax and exercise regularly.

Dr. Witoonpanich examines a patient with Kennedy’s disease at Ramathibodi Hospital as three neurology residents look on.
Hereditary Neuroblastoma Tied to ALK Gene Mutations

Three novel anaplastic lymphoma kinase germline variations are identified.

The investigators performed genome-wide linkage studies using a panel of approximately 8,000 single nucleotide polymorphisms (SNPs). This produced evidence of linkage to a 16.1 megabase region of chromosome 2p23-24 (log score = 4.23) containing 104 genes, including ALK and MYCN. (MYCN amplification is associated with poor prognosis in neuroblastoma.)

Recombination events were then mapped to this region to determine potential neuroblastoma predisposition genes. Genetic and pedigree analysis (based on a mean of four individuals with neuroblastoma and family) indicated that heritable mutations of the ALK tyrosine kinase domain (exons 21-28) are present in 8 of the 10 families studied.

Three novel variations of ALK germline mutations were identified: R1275Q (P = 0.91), which activates the BRAF oncogene and other protein kinases; G1128A (P = 0.5), which also activates BRAF; and R1192P (P = 0.98), which has an undetermined function.

Neuroblastoma is passed on through the germline in only 1% of the children affected, however.

Therefore, the investigators sought to determine the role of ALK mutations in somatically acquired neuroblastoma.

They speculated that acquired somatic mutations in the ALK gene can occur during evolution to the high-risk form of the disease. The notion that acquired mutations of ALK are likely to occur in neuroblastoma tumors such as BRAF is consistent with the two-hit model of oncogenesis.

In a panel of 491 tumors assessed, 112 had focal unbalanced gains of ALK, 16 of which had high levels of ALK amplification. ALK gain or amplification was associated with both high-risk disease (P less than 0.001) and increased disease-related mortality (P = 0.003).

A resequencing of the tyrosine kinase domain of ALK in 167 of the 491 primary neuroblastoma tumor samples showed that 24 of them had ALK mutations, including eight distinct single-base missense substitutions. Results suggest multiple mechanisms of ALK activation. Furthermore, the vast majority of somatically acquired ALK mutations fell within mutation ‘‘hot spots’’ observed in other cancers (for example, MET, ERBB2, and EGFR kinase).

Dr. Brian Kushner, a pediatric oncologist at Memorial Sloan-Kettering Cancer Center, New York, discussed the study, saying that “ALK is a very important marker in these familial neoplasms and is a promising target for therapy.”

In terms of developing new ALK-targeted drugs, Dr. Mosse said, “Fortunately, although neuroblastoma is a rare disease, we are not starting from scratch. ALK is an oncogene which is implicated in other human cancers, such as anaplastic large cell lymphoma. So there are many pharmaceutical companies who are very interested in developing ALK inhibitors; some have actually developed ALK programs.”

ALK is homologous to other kinases such as ABL and PDGFR, an inhibitor of which is now being tested in phase 1 studies in adults, she added. Researchers working in Dr. Mosse’s laboratory have identified many ALK mutations they discovered, and are performing ongoing transformation assays.

Migraine With Aura Linked To Increased CVD Risk

Dr. Chopra Wins Award

Dr. Chopra wins an award from the Government of India.
Calendar of International Events

**2008**

**NeuSIG Satellite to the Glasgow 2008 World Congress on Pain**
August 13-15, 2008; London
www.kenes.com/neuropathic2008

**XXIII Congresso Brasileiro de Neurologia**
August 16-21, 2008; Belém, Brazil
www.neuro2008.com.br

**12th Congress of the European Federation of Neurological Societies**
August 23-26, 2008; Madrid
www.kenes.com/efns2008

**6th International Conference on Frontotemporal Dementia**
Sept. 3-5, 2008; Rotterdam, The Netherlands
www.ftd2008.org/site

**6th International Congress on Meningiomas and Cerebral Venous System**
Sept. 3-7, 2008; Boston
www.themeningingomacconference2008.org

**European Headache and Migraine Trust International Congress 2008**
Sept. 4-7, 2008; London
www.ehmt2008.org

**14th World Congress of Psychophysiology**
Sept. 8-11, 2008; St. Petersburg, Russia
www.world-psychophysiology.org/iop2008

**World Congress on Treatment and Research in Multiple Sclerosis (ACTRIMS+ECTRIMS+LACTRIMS)**
Sept. 11-20, 2008; Monte Carlo
www.msmontreals.org

**7th Mediterranean Congress of Physical and Rehabilitation Medicine**
Sept. 18-21, 2008; Portorose, Slovenia
www.medcongress.prn08.org

**Xth International Symposium on Thrombolysis and Acute Stroke Therapy**
Sept. 21-23, 2008; Budapest, Hungary
www.kenes.com/tast2008

**8th European Congress on Epileptology**
Sept. 21-25, 2008; Berlin
www.epilepsyberlin2008.org

**5th World Congress for NeuroRehabilitation**
Sept. 24-27, 2008; Brasilia, Brazil
www.sarah.br/wnfrtco2008

**6th World Stroke Congress**
Sept. 24-27, 2008; Vienna
www.kenes.com/stroke2008

**XXVII Annual Congress of the European Society of Regional Anaesthesia and Pain Therapy**
Sept. 24-27, 2008; Genoa, Italy
www.kenes.com/esra

**36th Annual Meeting of the International Society for Paediatric Neurosurgery (ISPN)**
Oct. 12-16, 2008; Cape Town, South Africa
www.ispn2008.org

**6th International Congress on Mental Dysfunctions and Other Non-Motor Features in Parkinson’s Disease**
Oct. 16-19, 2008; Dresden, Germany
www.kenes.com/pdment2008

**Dystonia Europe 2008**
Oct. 17-19, 2008; Hamburg, Germany
www.dystonia-europe.org

**2nd World Congress on Controversies in Neurology**
Oct. 23-26, 2008; Athens
www.comtecmed.com/cony

**9th International Congress of Neuroimmunology**
Oct. 26-30, 2008; Fort Worth, Texas
www.nim2008.org

**Child Neurology Society Annual Meeting**
Nov. 5-8, 2008; Washington
www.childneurologysociety.org/annual_meeting/accomodations

**Neuroscience 2008**
Nov. 15-19, 2008; Washington
www.sfn.org/am2008

**2009**

**2009 AAN Regional Conference**
Jan. 14-18, 2009; Orlando, Fla.
www.aan.com/go/education/conferences

**7th International Symposium of Asian and Pacific Parkinson’s Association (APPA)**
Feb. 15-16, 2009; New Delhi
www.aopminda.com/apps/appa_invitation.html

**2nd Asian and Oceanian Parkinson’s Disease and Movement Disorders Congress (AOPMC)**
Feb. 15-17, 2009; New Delhi
www.aopminda.com

**9th International Conference on Alzheimer’s and Parkinson’s Diseases: Advances, Concepts and New Challenges**
March 11-15, 2009; Prague
www.kenes.com/adpd
The Federation of European Neurological Societies

The EFNS has expanded its activities, further promoting neurologic research and training

BY JACQUES L. DE REUCK
European Regional Director of the WFN

The European Federation of Neurological Societies (EFNS), which represents 42 countries, has successfully extended its international cooperation across the Mediterranean.

The resulting collaboration among European, African, and Arabic countries will benefit us all as neurologists and advocates for the specialty.

The EFNS has adopted as associated members the adjoining neurologic societies of the Mediterranean basin. The new member societies include those from Morocco, Algeria, Tunisia, Libya, Egypt, Lebanon, Syria, and Jordan.

These societies now share the same practical advantages as those in Europe. Neurologists in training can participate in all the education and exchange programs of the EFNS, and are eligible to apply for travel bursaries to participate in EFNS congresses when their research is accepted for presentation.

The EFNS supports the European Brain Council (EBC), which promotes neurologic research programs within the European Union. The council, launched by Jes Olesen, M.D., is supported in its brain research initiatives by various scientific societies; pharmaceutical companies; and the European Federation of Neurological Associations (EFNA), a patient organization.

The successful collaboration between the EFNS and the EFNA is demonstrated by EFNA's representation at EFNS congresses, where they organize sessions for patients.

The EFNS also supports international collaboration among established neurologic societies. If your organization would like to work with us in our efforts to promote the importance of neurologic research to the World Health Organization, please contact the EFNS head office, Breite Gasse 4-8, A-1070 Vienna, Austria, or e-mail us at headoffice@efns.org. Our Web site is www.efns.org.

Let These Images of Thailand Entice You to Join Us in Bangkok for the 2009 World Congress of Neurology

Learn more at: www.wcn2009bangkok.com

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