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WORLD NEUROLOGY

THE OFFICIAL NEWSLETTER OF THE WORLD FEDERATION OF NEUROLOGY

COURTESY DR. PHILIP BABATUNDE ADEBAYO

Dr. Philip Babatunde Adebayo (right) visited Cerrahpasa.

COURTESY DR. MEHILA ZEBENIGUS

Dr. Mehila Zebenigus received training at Hacettepe University.

INSIDE

Visits to Turkey Aid African Neurologists

BY TÜLAY KANSU, MD, AND AKSEL SIVA, MD

As a part of the World Federation of Neurology's Africa Initiative, the Turkish Neurological Society offered a 1-month visiting program for neurologists from African countries at Istanbul University Cerrahpasa School of Medicine and Hacettepe University School of Medicine in Ankara. Two candidates among 16 applicants from several African countries were selected by an evaluation committee consisting of members of the WFN Educational Committee and representatives of the Turkish Neurological Society (TNS). Their visit was sponsored by a grant provided from the TNS.

Dr. Mehila Zebenigus

Dr. Zebenigus from Addis Ababa, Ethiopia, visited the department of neurology at Hacettepe University Medical School, Ankara, during March 1-30, 2012. She was the first woman neurologist in her country. It was quite an experience for her when she landed in snow-covered Ankara, only to then leave when the trees had blossoms at the end of the month.

She attended the activities of EEG, video monitoring, EMG, single-fiber

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A Memorable Learning Experience at Cerrahpasa

BY PHILIP BABATUNDE ADEBAYO, MBBS

To my greatest delight, I received the news of my selection for the World Federation of Neurology Turkish department visit in October 2011, for which I am very grateful. The date of my visit was slated for March 2012. This period I learned would be busy enough to provide a good learning experience for me. Dr. Aksel Siva, together with Dr. Ersin Tan and Dr. Wolfgang Grisold, were quite helpful in providing the necessary documents I needed for obtaining my visa.

See **Cerrahpasa** • *page 15*

Program Ignites Enthusiasm For Building Relationships

BY MEHILA ZEBENIGUS, MD

First of all, I would like to express my deep appreciation to the Turkish Neurological Society and the World Federation of Neurology for organizing and sponsoring this visit. My special thanks go to the staff and students of the department of neurology at Hacettepe University and particularly to Dr. Tülay Kansu, who not only educated and mentored me, but also made sure that each day was comfortable and memorable.

During my stay in March 2012, I attended different activities in the elec-

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In This Issue of WORLD NEUROLOGY

EDITOR IN CHIEF'S COLUMN

Africa's Neurologist Shortage

JOHAN A. AARLI, MD

The World Federation of Neurology and other international neuroscience organizations can and should do more to address the lack of specialists in neurology in Africa by assisting African universities in establishing training programs in clinical neuroscience at their medical schools.

Why are there so few specialists in neurology in sub-Saharan Africa? Most African universities have their own medical schools, but the neuroscience curricula are not consistent. The World Federation of Neurosurgical Societies (WFNS) supported neurosurgery in Africa from the very beginning, but the World Federation of Neurology (WFN) has been more concerned about principles for organizing neurological societies. Sharon Juliano also recently pointed out that neuroscience and related disciplines are subjects feared and shunned by students of medicine and science in Africa.[1]

The main reason for this difference is not in the presentation of curricula for postgraduate education, but more in the differences presented by the WFN and the WFNS.[2] Although the WFNS almost immediately admitted African neurosurgeons into their international system, the WFN required the integration of trained neurologists even before their presence in the national health system. According to the rules, any national society of neurologists with more than five members may apply for membership in the WFN, and can nominate a delegate with a voting right to the Council of Delegates. WFN membership is therefore restricted to national neurological societies comprising qualified neurologists.

However, in 2006, the Council of Delegates concluded that the WFN should be inclusive rather than exclusive in accepting membership applications. It is a part of the mandate of the WFN's Africa Initiative to monitor the status of neurology training in sub-Saharan Africa. The Africa Initiative therefore seeks to address the special problems faced by countries on the African continent.

IN 2004, ONLY HALF OF THE COUNTRIES IN THE AFRICAN WHO REGION THAT COMMUNICATED WITH THE WHO HAD A NATIONAL NEUROLOGICAL ASSOCIATION.

Let me use this occasion to thank the Turkish Neurological Society for making this possible, and the WFN Education Committee for their work. There were 16 applicants from various countries, and two of them have been selected. Philip Babatunde Adebayo from Nigeria visited at Cerrahpasa, and Mehila Zebenigus from Ethiopia at Hacettepe. I am impressed by what I have read, both the excellent preparatory work made by the Turkish colleagues, and the presentations of modern neuromedicine made visible to the guests.

Continued on following page

WFN Is a Regional Organization

The WFN is an integrated part of a network formed by the WHO, the coordinating authority for health within the United Nations, as well as by governmental and nongovernmental health administrations. It is important for the WFN, with its geographical and regional programs, to operate within the geography of the WHO, whose structure serves as a model for regionalization of neurology and other specialty-related organizations.

The WHO is not structured according to the clinical specialties in medicine. It is a governmental organization with a main responsibility for public health, so its member nations are grouped into six geographical regions (the African, American, South-East Asian, European, Eastern Mediterranean, and Western Pacific regions). Some nations have been assigned to regions outside their traditional geographic area. Algeria is a part of the WHO African region and not of the Eastern Mediterranean region, whereas Morocco, Tunisia, Libya, Egypt, Eritrea, Sudan, and Somalia are outside the WHO African region.

Each WHO region has its own regional office; in Brazzaville, Congo, for the African region; in New Delhi, India, for the South-East Asian region; in Washington, DC, USA, for the American region; in Copenhagen, Denmark, for the European region; in Cairo, Egypt, for the Eastern Mediterranean region; and in Manila, Philippines, for the Western Pacific region.

The WFN regional system is based upon the WHO structure. There are two main structural differences from the WHO. The WFN found it practical to have one North American and one Latin American region because neurology is so well developed in the Americas, and also for linguistic reasons. The WFN Asian-Oceanian Region comprises the South-East Asia and Western Pacific WHO regions.

The WHO South-East Asia Region comprises Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor Leste. The WHO Western Pacific Region is huge, with approximately 1.6 billion inhabitants and nearly one-third of the world's population.

World Neurology

World Neurology, an official publication of the World Federation of Neurology, provides reports from the leadership of the WFN, its member societies, neurologists around the globe, and news from the cutting edge of clinical neurology. Content for **World Neurology** is provided by the World Federation of Neurology and IMNG Medical Newswire.

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PRESIDENT'S COLUMN

On the Horizon

VLADIMIR HACHINSKI, MD

The digital age is proving more revolutionary than the re-invention of the printing press over half a millennium ago. It can connect individuals instantly across the globe in different visual and auditory forms and it allows a quality and speed of exchange of communications unprecedented by any previous medium.

One of the first priorities of the current administration was to upgrade the World Federation of Neurology (WFN) and make its website more dynamic. It is increasingly being used as a medium of providing and exchanging information. WORLD NEUROLOGY, our bimonthly publication, is about to go digital, according to the decision of the new editor in chief, Johan Aarli.

The advantage of the printed version is that it is easy to scan and to carry in all sorts of situations. On the other hand, it is becoming increasingly expensive to print and distribute the printed version, and there is a delay between the completion of the content and its delivery.

The online version offers faster communications and access to features that are impossible to provide in a printed version, such as videos. The transition is likely to take place this year.

The activities of the WFN have increased considerably during this administration and have therefore required enhanced infrastructure and support. In a meeting of the Trustees in February of this year, it was decided that there is an advantage in keeping the London office. However, this will be supplemented by hiring help from professional organizations for particular activities, such as enhanced technologies.

As I reported in this column in June 2012, we invited representatives from nine other organizations to participate in the process for this year's grant-in-aid competition: the World Federation of Neurosurgical Societies, the International Child Neurology Association, Multiple Sclerosis Research Australia, the European Federation of Neurological Societies, the International Brain Research Organization, the International League Against Epilepsy, the World Stroke Organization, the American Academy of Neurology, and The Movement Disorder Society. Part of our aim was to learn what initiatives were arising across the broad field of brain-related activities.

CANDIDATES AT THE DELEGATES' MEETING ON SEPT. 9 WILL HAVE THE OPTION OF APPEARING IN PERSON OR BY SKYPE OR EQUIVALENT FOR THE FIRST TIME.

Secondly, it would provide an opportunity to give larger grants if the projects were of interest to more than one organization. Finally, the participation of additional organizations might help to fund more projects by avoiding overlap and ensuring a more uniform standard. The fact that 10 different individuals from different time zones could interact through the Internet to make decisions is in itself a tribute to the electronic age. Overall, 83 letters of intent were submitted, and 13 have been invited to send more extensive submissions. Some of the successful applications will probably be co-funded by the WFN and one or more of the other brain-related organizations.

Virtual Attendance at Delegate Meetings

Most of the annual meetings of WFN delegates have taken place in conjunction with the annual meetings of the European Federation of Neurological Societies or the American Academy of Neurology, except for the years when there has been a World Congress of Neurology. When the meeting of delegates takes place as a part of a meeting that fewer neurologists attend, it provides an unfair advantage to the small minority who can travel and who are often armed with proxies that multiply voting power. This can produce unexpected results.

At the delegates' meeting that will take place in Stockholm on Sunday, Sept. 9, 2012, the candidates for Elected Trustee for the first time will have the option of appearing in person or by Skype or equivalent.

The ability to participate may be extended eventually beyond candidates for office to all delegates, so that those who cannot attend physically can participate via the Internet. That would not only enhance the ability of delegates to contribute, but it would make the process more democratic because everyone will have an equal chance to be a candidate or a participant. The Constitution and Bye-Laws Committee is deciding whether to recommend this option to delegates as well for the World Congress of Neurology meeting in Vienna, Sept. 21-26, 2013.

The Internet and digital communications have allowed an unforeseen ability to communicate and to interact. They can magnify what we can accomplish, but at the same time they tend to fragment what we do, bombarding us constantly with messages that are consistently insistent, but inconsistently relevant.

The great challenge of the digital age is to surf the rising seas of information successfully without drowning in data. Technology is a magnificent tool. We must remain its masters. ■

Continued from previous page

Postgraduate training in clinical neuroscience is an important goal for several organizations related to neurosciences: the World Health Organization (WHO), the International Brain Research Organization (IBRO), the European Federation of Neurological Societies (EFNS), the International League Against Epilepsy (ILAE), and the WFN.

Two relevant examples of a lack of postgraduate training in clinical neuroscience are the medically advanced countries of Ghana and Tanzania. Neurosurgery is well established in both countries, which also have active epilepsy associations. Ghana has a population of more than 20 million people, and there are five public universities. In 1988, the Eighth Pan African Association of Neurological Societies (PAANS) Congress took place in Accra. Unfortunately, Prof. James Mustaffah, the doyen of neurosciences in Ghana, passed away in 1999, with harmful consequences.[2] Tanzania is twice as big as Ghana with a population of 43 million people, and has been spared the internal strife and conflicts of many neighboring countries. But neither Ghana nor Tanzania has a national neurological association. In 2004, only half of the countries in the African WHO Region that communicated with the WHO had a national neurological association.[3]

The WHO system is based upon a public health system. Important sources of information are the reported frequencies of neurological disorders and of neurological service in primary care, the number of neurological beds, financing for neurological services, and disability benefits. The number of specialists in neurology is lower in Africa than in the other WHO regions; the median number of neurologists per 100,000 population is extremely low in Africa (0.03 vs. 0.07 in Southeast Asia, 0.32 in the Eastern Mediterranean, 0.77 in the Western Pacific, 0.89 in the Americas, and 4.84 in Europe).[3] The WHO report demonstrated a lack of trained neurologists in Africa.

THE NUMBER OF SPECIALISTS IN NEUROLOGY IN AFRICA, AT 0.03 PER 100,000 POPULATION, IS LOWER THAN IN THE OTHER WHO REGIONS.

Epilepsy is at the forefront of neurological health problems in Africa and must be viewed from the public health perspective. The care of patients with epilepsy in sub-Saharan Africa is mainly provided by nonspecialists. If there are no neurologists, then general practitioners, neurological nurses, and other groups of health personnel are even more important and necessary. But they are not trained to diagnose and treat epilepsy, which is the most common neurological disorder seen in primary care in developing regions of the world. And after a first seizure, patients with epilepsy may go years without appropriate therapy.

The EFNS has pioneered establishing Teaching Tools Workshops in Africa, and has had strong support from the WFN, the IBRO, and the WHO. The first Teaching Tools Workshop in neuroscience was held in Senegal in 2009, and 27 students from 11 different countries attended the most recent Teaching Tools Workshop in Ghana.[1]

The ILAE also has a broad network in Africa and works closely together with the WHO.

These organizations, when working together, can be even more active in assisting African universities in establishing training programs in clinical neuroscience at their medical schools. We need specialists with training in modern treatment of epilepsy. ■

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Council of Delegates Meeting

This year's Council of Delegates meeting will be held on Sunday, Sept. 9, 2012, during the European Federation of Neurological Societies meeting in Stockholm.

The meeting will begin with a buffet lunch from 12 p.m. to 1:00 p.m., followed by the meeting itself from 1:00 p.m. to 4:00 p.m. The venue for the meeting will be confirmed shortly; please keep an eye on our website for further information at www.wfneurology.org. ■

WFN Seeks Officer Nominations for 2013 Elections

On ballot: President, First Vice President, Secretary-Treasurer General, and Elected Trustee.

In accordance with the Memorandum and Articles of Association of the World Federation of Neurology, the election of three new officers and one new Trustee, as shown below, must take place at the Annual General Meeting of the Council of Delegates during the World Congress of Neurology in Vienna, Sept. 21-26, 2013.

The officer and Trustee positions are the following:

- President (to take up office starting Jan. 1, 2014)
- First Vice President (to take up office starting Jan. 1, 2014)
- Secretary-Treasurer General (to take up office starting Jan. 1, 2015)
- One Elected Trustee (to take up office starting Sept. 22, 2013)

Candidates for President and First Vice President will be required to formulate a statement of their goals and objectives for the organization, which will be published.

If you wish to propose a candidate for any of these posts, please be in touch with either your national society or WFN Delegate (whose name appears on the WFN website: www.wfneurology.org).

Names of those who are willing to serve and who receive the official support of their national society must arrive at the WFN London headquarters office by Nov. 16, 2012, to enable the Nominating Committee to consider them at a meeting to be arranged.

All admissions received will be scrutinized by the Nominating Committee according to the Guidelines that are published on the WFN website. The names of candidates will be published in World Neurology and on the WFN website at least 6 months before the date of the election. Additional nominations may be submitted by five or more Delegates at least 30 days before the AGM.

All submissions should be sent to:

The WFN Nominating Committee
c/o Keith Newton
Executive Director
WFN London Office
Hill House, Heron Square
Richmond, Surrey, TW9 1EP
United Kingdom

There will be a degree of overlap between old and new administrations in two ways: The term of office of the current Secretary-Treasurer General will continue until Dec. 31, 2014, and two of the three Elected Trustees already in post at the time of the Congress will also continue to hold office, for 1 and 2 years, respectively. ■

MEETING REPORT

Nairobi Symposium Brings African Neurologists Together

BY EVELYN SIPIDO AND ERICH SCHMUTZHARD, MD

Following 4 years of successful Regional Teaching Courses in sub-Saharan Africa, the World Federation of Neurology, the European Federation of Neurological Societies, and the International Brain Research Organization put together a 1-day symposium in Nairobi, Kenya, on June 20, 2012. It met with great success and requests for multiday programs in the future.

The symposium took place at Aga Khan University Hospital and was held in conjunction with the first African Epilepsy Congress, which also took place in Nairobi during June 21-23, 2012.

The symposium was attended by 70 neurologists, neurologists in training, internists, and other physicians, representing 15 African countries.

Contributions from the three organizations made it possible to invite and sponsor a number of trainees from the neighboring countries to Kenya to attend the symposium. All the invited neurologists in training were specifically recommended by the head of their local departments of neurology.

The trainees who attended the symposium included Dr. Tafa Samson Alemayehu (Ethiopia), Dr. Jenala Mphatso Njiram'madzi (Malawi), Dr. Natalie Govender (South Africa), Dr. Haoua O. Sidibe (Senegal), Dr. Patience Luoga (Tanzania), Dr. Rita Atugonza (Uganda), and Dr. Clarance Chiluba (Zambia).

African colleagues and students chose the focus points of the program, which were multidisciplinary approaches to pediatric neurology and neuroepidemiology in sub-Saharan Africa. Here are some highlights of speakers' presentations:

- **Jo Wilmshurst** (**South Africa**) spoke about neurological complications of HIV in children, in particular, in Cape Town. She said that the earlier children with HIV are diagnosed as being neurologically and neurocognitively impaired, the better the prospects they may have for treatment and prognosis.
- **Richard Idro** (**Uganda**) discussed cerebral malaria and its complications, including neurocognitive deficits, language and language development impairment, epilepsy, and dropping out of school.
- **Pauline Samia** (**Kenya**) discussed cerebral palsy and its management, delineating very clearly how it was possible to do so within an African community and proving that many therapeutic approaches are possible even in resource poor countries.
- **Simon Heales** (**United Kingdom**) addressed neurometabolic disorders in children, concentrating on pyridoxine deficiency and folate deficiency.
- **Amadou Gallo Diop** (**Senegal**), the WFN delegate to the symposium, provided insight into the training and care for populations living far from capital cities and health care access in sub-Saharan Africa by discussing the Senegalese experience of so-called neurocaravans. The neurocaravan approach has the motto "bring the doctor/specialist and the medicine to the people" and not vice versa.
- **Jenala Mphasto Njiram'madzi** (**Malawi**) concluded the morning session with an extraordinary clinical case presentation from Malawi about adrenoleukodystrophy.
- **Erich Schmutzhard** (**Austria**) talked about the prevalence and incidence of primary headache in sub-Saharan Africa, highlighting the importance of tension-type headache and migraine with and without aura, even in the health care of rural sub-Saharan Africa.
- **Raj Kalaria** (**United Kingdom**), a delegate from the IBRO, discussed the epidemiology of neurodegenerative disorders, and in particular dementia, in rural and urban sub-Saharan Africa, indicating the growing importance of these neurological disorders in urban as well as rural African communities.
- **Dismand Houinato** (**Benin**) talked about specific peculiarities of stroke in sub-Saharan populations with respect to age, risk factors, clinical presentation, and outcome.

Courtesy Raj Kalaria

Attendees of the Nairobi symposium heard presentations focused on multidisciplinary approaches to pediatric neurology and neuroepidemiology in sub-Saharan Africa.

An open discussion ended an extremely intensive working day, which was full of new insights into communicable and metabolic neurological disorders in African children and the epidemiology of basic neurological diseases in sub-Saharan Africa. These new insights prompted a very lively discussion between the speakers and the very interested and highly motivated audience.

On evaluation forms, all attendees fully agreed that a 1-day symposium or Regional Teaching Course was far too short, and regularly requested prolonging this educational course to at least 2.5 or 3 days, as had been done in the previous years. (This year, this teaching course was shortened to 1 day because of financial restrictions and the start of the first African Epilepsy Congress.)

Very positive feedback was otherwise received on the evaluation forms, and we received many proposals for potential future Regional Teaching Courses.

Overall, this symposium showed that African and European physicians and scientists are absolutely willing and committed to communicate, collaborate, and pursue the common goal of spreading neurology in sub-Saharan Africa.

Attendees especially thanked Ms. Evelyn Sipido for her organizational work toward the success of the symposium. ■

Ms. Sipido is a liaison officer to the European Federation of Neurological Societies in Florence, Italy. Dr. Schmutzhard is deputy director of the department of neurology and head of the neurointensive care unit at University Hospital Innsbruck, Austria.

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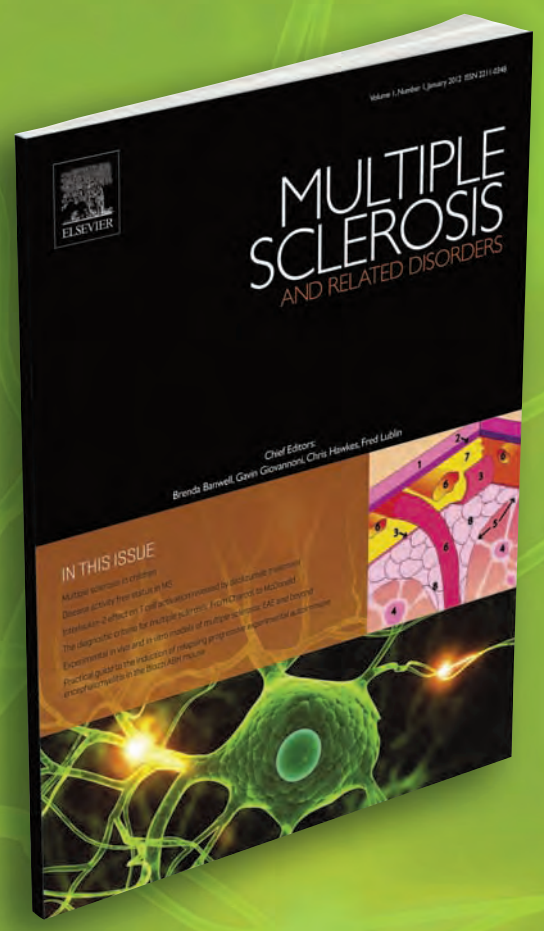

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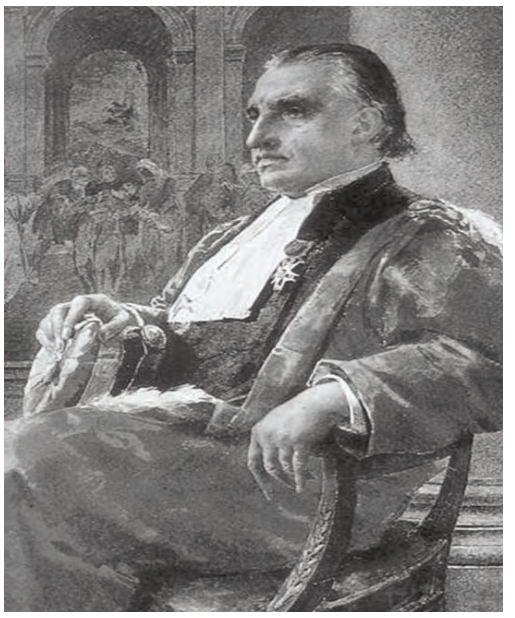
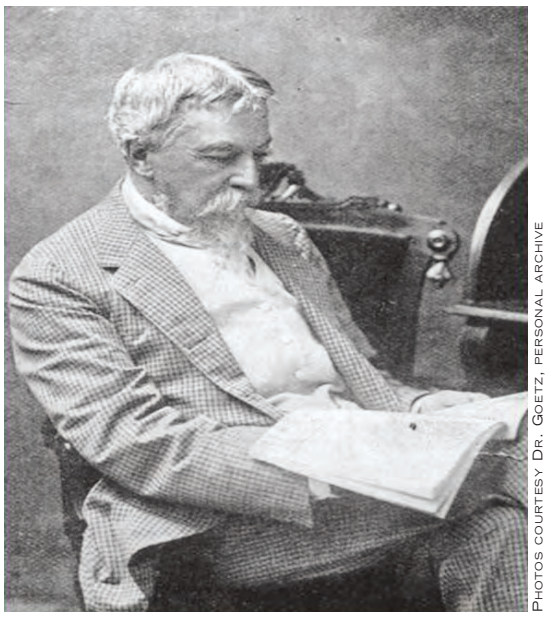
FROM THE WFN HISTORY GROUP

Neurological Pioneers, Admirers Across the Atlantic



Jean-Martin Charcot (1825 -1893)



Silas Weir Mitchell (1829 - 1914)

Photos courtesy Dr. Goetz, personal archive

During the last quarter of the 19th century, both in the United States and in France, the field of neurology emerged as an autonomous medical specialty.[1] The most internationally celebrated university professor was Jean-Martin Charcot, whose neurological school at the Salpêtrière Hospital in Paris became the prototypic model for future programs worldwide.[2]

Along with William A. Hammond, Charcot's major American contemporary was Silas Weir Mitchell.[3] Charcot and Mitchell interacted at multiple intellectual levels, and though their personal contact was modest, they followed each other's careers closely, cross-referencing one another, usually with respect and sometimes with antagonism. They shared several neurological interests and developed similar philosophical approaches to neurology.

Charcot never visited the United States, but Mitchell voyaged to Paris as a student and later in 1873 and 1875.[2,4] Whether or not he actually met Charcot in 1873 – or simply attended public lectures – is unclear, but in 1875, he specifically sought out Charcot and his increasingly well-known neurological service at the Salpêtrière. The visit was peculiar, almost theatrical, for Mitchell arrived, not as a colleague, but as an anonymous patient, suffering from overwork. His student recounted the event:

"Charcot examined him and gave a few simple directions, and then turning to him asked him where he was from. Mitchell told him he was from Philadelphia. Then Charcot said: 'You have a man in Philadelphia who knows more about run-down nervous conditions than anyone else I know of, and I will give you a letter to Dr. S. Weir Mitchell, whom you must consult.' The situation was so ludicrous that Mitchell laughed, and when Charcot asked him what he was laughing about, Mitchell handed him his card."[5]

In several areas of neurological research, Charcot and Mitchell interfaced. Charcot alluded to Mitchell's "Injuries of Nerves and Their Consequences" as a "remarkable work,"[6] and Mitchell cited Charcot's observations in several clinical areas.[7] Charcot openly admired Mitchell's observations on phantom limbs after amputation, suggesting that these cases spoke both to neurophysiology as well as neuropsychology.[6]

To contrast with these examples, there are occasional examples reflecting a less congenial spirit on Mitchell's part. Most examples concerned issues of French vs. American primacy in original clinical descriptions. Writing about neuropathic arthropathies, most often seen in tabes dorsalis, Mitchell commented:

"The history of spinal arthropathies is well told by Charcot. ... The history of this subject is somewhat interesting, and the more so, because to an American physician belongs the long-forgotten credit of the first discovery that 'an obvious spinal cause may produce a rheumatism.' The quotation is taken from the second paper on rheumatism by my father, the late Dr. John K. Mitchell."[8]

In fact, Mitchell's condemnation was poorly founded, and he apparently read French less well than Charcot read English. In 1868, Charcot had alluded to the senior Mitchell, calling specific attention to his observation on joint affections in the context of "caries of the spine with compression of the spinal cord".[9]

In several ways, Charcot and Mitchell helped to lay philosophical foundations that guided the development of early international neurology and specifically marked the French and American schools. First, both men were strong advocates of clinical medicine as the pillar of neurology. In contrast to the growing Prussian emphasis on laboratory science, Charcot and Mitchell held to the principle that neurological advances must always begin and end with clinical analyses. In addition, Charcot and Mitchell taught their neurological students the fundamental element that drives a physician toward medical advances. Reflecting on a patient with amyotrophic lateral sclerosis, for which he acknowledged his impotency to treat, Charcot commented to his students:

"Let us keep looking, in spite of everything. Let us keep searching. It is indeed the best method of finding, and perhaps, thanks to our efforts the verdict we will give to such a patient tomorrow will not be the same as that we must give today."[6]

More succinctly, Mitchell expressed a similar stance, by describing the anchoring trait of true physicians: "Not to know surely is to them a form of unhappiness."[10]

BY CHRISTOPHER G. GOETZ, MD

Dr. Goetz is director of the Parkinson's and movement disorders program at Rush University, Chicago, USA.

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Peter J. Koehler, MD, PhD, *is the editor of this column. He is a neurologist in the department of neurology at the Atrium Medical Centre, Heerlen, the Netherlands. Visit his website at www.neurohistory.nl.*

Michael Prize 2013

The Michael Prize was awarded for the first time in 1963 to stimulate epilepsy research in Germany; it is now one of the most highly regarded international awards for the best contribution to scientific and clinical research that promote further developments in epileptology.

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For the Michael Prize 2013, up to a maximum of three papers in the English language may be considered, at least one of which – published or not yet published – must be from the period 2011-2012. The papers, together with a curriculum vitae, should be submitted by electronic mail to Stiftung Michael before Dec. 31, 2012.

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Courtesy Michael Foundation

WFN COURSE REPORT

First Neurology Certificate Course in Kabul a Success

Attendees of the first Neurology Certificate Course in Kabul, Afghanistan, praised the interactive program that was organized in collaboration with the Afghanistan Ministry of Public Health, Aga Khan University Programs in Afghanistan, and the French Medical Institute for Children, Kabul.

I and Dr. Mughis Sheerani, another senior neurologist from Aga Khan University in Karachi, Pakistan, conducted the course during May 20-24, 2012; the course was funded by an educational grant from the World Federation of Neurology.

BY MOHAMMAD WASAY, MD

Dr. Wasay is secretary of the Pakistan Neurology Society and serves as its delegate to the WFN. He is an associate professor of neurology at the Aga Khan University in Karachi, Pakistan.

The Ministry of Public Health circulated information about the course on a poster to all major medical centers and universities in Afghanistan and on the Internet. Of more than 70 physicians who applied for the course, 40 (including 5 women) were selected based on previous training and interest in neurology, and 34 (including 4 women) participated in the course. These included internists, family physicians, psychiatrists, neurologists, neurosurgeons, pediatricians, and trainees at various hospitals.

The 5-day course had an interactive program covering all important topics in neurology, including neurological history and examination, brain and spine imaging, stroke, epilepsy, headache, movement disorders, and CNS infections. The course also included case presentations from local participants. All participants received course material in CDs, including copies of all presentations and a book in neurology.

The educational value of the course was measured through the amount of knowledge participants gained since taking a pretest before the start of the course, according to a posttest taken at the end. Dr. Najeeb Sikander, a neurosurgeon at Ibne Sina Emergency Hospital in Kabul, said that "this was the best course I have ever attended. It will certainly help us in treating neurological disorders according to international standards."

Dr. Abdul Wahid Sabet, program director of the pediatrics residency program at the French Medical Institute for Children, and associate professor at Kabul Medical University, said, "This course has really changed our perception of neurology and current neurology practice in Afghanistan. I feel like a neurologist after participating in this course."

The chief guest, Dr. Ihsanullah Shahir, general director of Afghanistan's Ministry of Public Health, chaired the closing ceremony of the course and applauded the WFN for supporting the organization of the first-ever neurology course in Kabul. He distributed certificates to participants.

Dr. Farhat Abbas, dean of the medical college at Aga Khan University, said, "This is a superb contribution and I am so glad to see that through the outstanding efforts of AKU faculty, AKU is making such meaningful contributions towards capacity building in areas of dire need in Afghanistan." ■

PHOTOS COURTESY DR. MOHAMMAD WASAY

A group photo of course participants with facilitators and chief guest Dr. Ihsanullah Shahir (front, center, black coat, no tie) in the courtyard of the French Medical Institute for Children, Kabul. To the right of Dr. Shahir is Dr. Mughis Sheerani (blue coat and blue striped tie) and to the left is Dr. Parvez Nayani and Dr. Mohammad Wasay.

A view of the course participants at the French Medical Institute for Children conference room in Kabul. The 5-day course had an interactive program covering all important topics in neurology, including neurological history and examination, brain and spine imaging, stroke, epilepsy, headache, movement disorders, and CNS infections.

Calendar of International Events

2012

16th Congress of the European Federation of Neurological Societies
September 8-11, 2012
Stockholm, Sweden
www.efns.org/efns2012

Asia Pacific Stroke Conference 2012 (APSC2012)
Sept. 10-12, 2012
Tokyo, Japan
www2.convention.co.jp/APSC2012/index.html

10th European Congress on Epileptology (ECE)
September 30 – October 4, 2012
London, UK
www.epilepsylondon2012.org

28th Congress of the European Committee for Research and Treatment in Multiple Sclerosis (ECTRIMS)
Oct. 10-13, 2012
Lyon, France
www.congrex.ch/ectrims2012

8th World Stroke Congress (WSC 2012)
October 10-13, 2012
Brasilia, Brazil
www2.kenes.com/stroke/Pages/Home.aspx

2nd International Congress on Neurology & Epidemiology
Nov. 8-10, 2012
Nice, France
www.neuro-conference.com

2013

International Headache Society (IHS): International Headache Congress
June 27-30, 2013
Boston, Mass., USA
www.americanheadachesociety.org/events/2013_international_headache_congress/

XXI World Congress of Neurology
Sept. 21-26, 2013
Vienna, Austria
www2.kenes.com/wcn/Pages/Home.aspx

Family History Tops Parkinson's Disease Risk Factors

Some risk factors were associated with reduced odds of disease, such as smoking and coffee drinking.

BY MITCHEL L. ZOLER
IMNG Medical News

A family member with Parkinson's disease confers the strongest risk for developing the disease, according to findings from the largest and most comprehensive systematic review and meta-analysis of Parkinson's disease risk factors suitable for screening in primary care.

People with a first-degree relative with PD had a more than threefold higher odds for developing PD themselves, compared with those without an affected first-degree relative, based on a meta-analysis of data from 26 case-control studies, and people with any relative with PD had a 4.5-fold greater odds, according to data collected in 19 case-control studies, Dr. Alastair J. Noyce and his associates reported (Ann. Neurol. 2012 July 10 [doi: 10.1002/ana.23687]).

Dr. Noyce, a researcher in the Institute of Neurology, University College London, and his colleagues identified 202 English-language articles published during 1966-March 2011, of which 173 made it into the meta-analysis. Included studies involved several hundred thousand patients in cohort studies, and several tens of thousands in case-control studies. The new review and analysis used "an extensive search of observational studies to calculate effect sizes of multiple risk factors for PD," the study authors wrote.

The meta-analysis found 19 risk factors that significantly linked with an altered risk – increased or decreased – for future development of PD, and assessed 11 additional factors that did not show a statistically significant link to PD. Following family history of PD, other strong associations identified in the meta-analysis included:

19 FACTORS ALTERED THE RISK FOR PARKINSON'S DISEASE IN THE LARGEST, MOST COMPREHENSIVE SYSTEMATIC REVIEW AND META-ANALYSIS OF ITS KIND.

- Family history of tremor, which boosted the odds for development of PD 2.7-fold, based on results from 10 case-control studies.
- Constipation, considered an early symptom, which was associated with a 2.3-fold greater odds for PD, based on data from one case-control and one cohort study.
- Mood disorder, another early symptom, which was linked to an 86% higher odds of PD, based on data from 11 case-control and 2 cohort studies.
- Pesticide exposure, a risk factor that was linked to a 78% higher odds, according to data from 36 case-control and 2 cohort studies.
- Head injury, a risk factor associated with a 58% greater odds in 19 case-control studies.

Both constipation and mood disorders may correlate with brainstem involvement, an early effect of PD, the authors wrote.

The analysis identified four other risk factors that were linked to an increase in the odds of developing PD of less than 50% but still reached statistical significance: rural residence (43% greater), beta-blocker use (28%), farming or agricultural work (26%), and well water use (21%).

The remaining eight significant risk factors were all associated with reduced odds for PD. Leading this category was smoking. Current smokers had 56% lower odds, compared with never-smokers, based on data from 26 case-control studies and 7 cohort studies. People who had ever smoked had a 36% reduced odds compared with never smokers, and past smokers had a 22% reduced odds. Other protective factors were coffee drinking, linked to a 33% drop in odds; hypertension, linked to a 26% reduction in odds; use of nonsteroidal anti-inflammatory drugs, associated with 17% lower odds; and use of calcium channel blockers and alcohol, each of which was linked to 10% reduced odds.

The analyses failed to find significant links between development of PD and other proposed risk factors or protective agents, including oral contraceptives, surgical menopause, hormone-replacement therapy, aspirin, acetaminophen, statins, or a history of diabetes. ■

VITALS

Major Finding: Having a relative with Parkinson's disease was linked to a 4.5-fold increased risk for developing the disease, compared with no family history.

Data Source: Data came from a meta-analysis of 173 case-control or cohort studies published during 1966-2011.

Disclosures: Dr. Noyce and his associates said that they had no disclosures.

Predictors of Impulsivity Disorders in Parkinson's Discovered

BY M. ALEXANDER OTTO
IMNG Medical News

NEW ORLEANS – Dopamine agonist–induced impulse control disorders may be more likely in Parkinson's disease patients who smoke, drink, or consume caffeine, according to the first prospective cohort study of the problem.

VITALS

Major Finding: The peak dose of dopamine agonists was higher among Parkinson's disease patients on dopamine agonists who developed impulse control disorders than it was in patients without the disorders (median, 300 vs. 165 levodopa equivalents).

Data Source: This is a prospective cohort study of 46 Parkinson's disease patients on dopamine agonists.

Disclosures: The study was supported by the Parkinson's Disease Foundation. Mr. Bastiaens said that he had nothing to disclose.

"We found a number of interesting things" when the 18 patients (39%) in the study who developed an impulse control disorder (ICD) were compared with the 28 who did not, said lead author Jesse Bastiaens, a medical student at Cornell University, New York.

The 18 had a higher baseline prevalence of caffeine use (100% vs. 67%; $P = .007$), lifetime prevalence of cigarette smoking (44% vs. 14%; $P = .04$), and cumulative exposure to both caffeine (72 vs. 38 cup-years; $P = .04$) and cigarettes (median 2 vs. 0 pack-years; $P = .07$). There was also a nonsignificant trend towards a higher baseline prevalence of alcohol use.

At baseline, patients with an impulse control disorder also had a greater prevalence of motor complications (61% vs. 25%; $P = .01$) and lower baseline modified Hoehn and Yahr Scale scores (mean 1.6 vs. 1.9; $P = .05$), despite comparable total Parkinson's disease (PD) drug use in both groups (median, 150 levodopa equivalents in both groups).

Impulse control disorder patients had higher peak-dopamine agonist (DA) doses (median, 300 vs. 165 levodopa equivalents; $P = .03$) but no significant differences in DA treatment duration or cumulative exposure.

"The risk of ICDs [impulse control disorders] in PD is related to both patient-specific factors and peak DA dosage. Attention to these susceptibility factors may help to reduce the incidence of ICDs in PD," Mr. Bastiaens said at the annual meeting of the American Academy of Neurology.

Besides counseling patients about the risk, "you might be less eager to use a dopamine agonists or use lower doses in people with prior histories of smoking or heavy drinking or other addictive behaviors," said Dr. Ronald Pfeiffer, vice chair of the department of neurology at the University of Tennessee, Memphis, who moderated Mr. Bastiaens' presentation.

Patients who developed an impulse disorder did so after a mean treatment duration of 23 months (range, 3-114 months). Age, age of PD onset, sex, depression, anxiety, and other factors were not predictive.

None of the 46 patients (all outpatients) had previous histories of impulse control disorders, and none were demented. Their mean age was 62 years, and about half were women. ICD was diagnosed by semistructured interviews and clinical data, with criteria that were perhaps a bit less strict than were those in the DSM-IV, according to Mr. Bastiaens, who said that the researchers thought that casting a slightly wider net might be useful.

'THE RISK OF [IMPULSE CONTROL DISORDERS] IN PD IS RELATED TO BOTH PATIENT-SPECIFIC FACTORS AND PEAK [DOPAMINE AGONIST] DOSAGE.'

There was 1 case per 100 person-months of DA exposure. "We found that impulse control disorders can really occur at anytime during dopamine agonist therapy – as early as 3 months or 9 or more years," said Mr. Bastiaens, who noted that a questionnaire to assess for ICDs in Parkinson's patients has been recently validated (Mov. Disord. 2012;27:242-7).

A 2010 cross-sectional study in 3,090 Parkinson's patients found an association between ICDs and current cigarette smoking and family histories of gambling problems, among other factors. It did not find an association with DA dosage. Just over 17% of patients on the drugs developed ICDs (Arch. Neurol. 2010;67:589-95). ■

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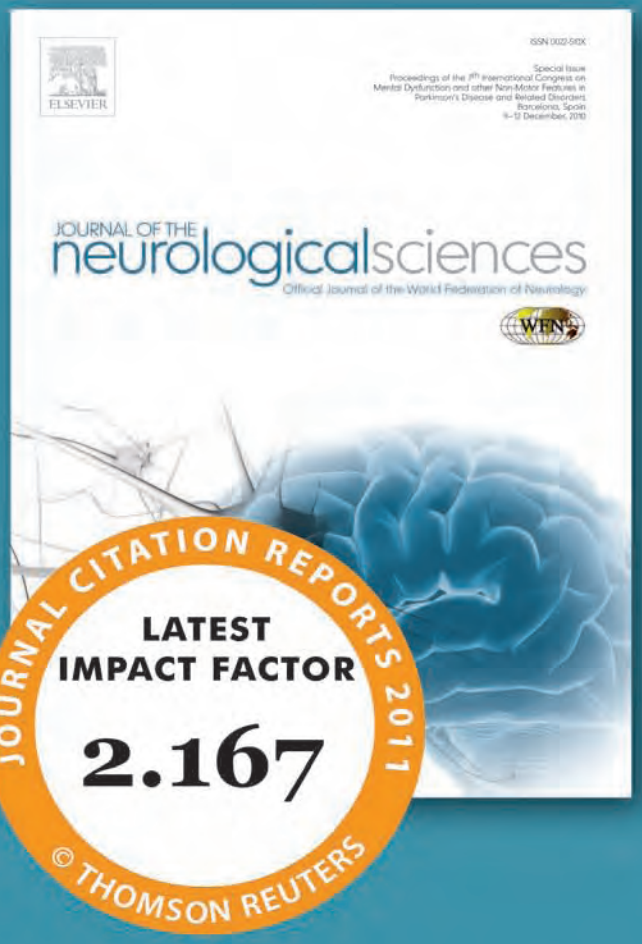

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ELSEVIER

Serving the WFN: A Neurologist Remembers Caxias

This is the second and final part of Dr. Wadia's remarkable story about his imprisonment in Portugal.

BY NOSHIR H. WADIA, MD

Dr. Wadia is emeritus director of neurology at Jaslok Hospital and Research Centre, Mumbai, India.

It was clear that we were in a desperate situation, and I began preparing myself for a long stay in Caxias. I worried about what was happening at home to my family, my friends, and my department, which I had so carefully nursed.

We were never subjected to any torture, but such thoughts were never far as we could hear cries of others who were being treated more harshly, and maltreatment of hostages in totalitarian regimes was always well known. I could not interact in any way with the outside world, as we were not allowed to write and we were not given paper to do so in the first month. A Portuguese lawyer, possibly sent through some Jesuit teachers from my old school, and Amnesty International came to see me and asked if I wanted to plead for habeas corpus. I told him to give me more time to consider the implications of this appeal before the Portuguese court.

However, I later refused appealing to the court because another Indian prisoner, who we had come to know was a lawyer, advised me not to. He was from Goa but had been in solitary confinement over many years in a cell just across a small passage outside the toilet which separated us. To talk to him, I opened the slot in his steel door, oiling it with sardine oil to avoid making any noise, while my cell mates watched the main corridor outside our cell to warn me about the arrival of guards.

The lawyer was taken aback when I spoke in a local language, Marathi, but was delighted to hear it. He gave me his name and said he had been in and out of this prison over many years, having been captured for dissidence in Goa and extradited to Lisbon permanently. He said, "If you apply for habeas corpus, you will be booked for 20 years, as they will plant some false evidence to implicate you in a crime or espionage. So keep quiet and patiently wait to see how events unfold."

One day a guard told me that there was a letter and a parcel sent by Prof. Pedro Manuel deAlmeida Lima, which was a great surprise. I knew of Prof. Lima as a famous Portuguese neurosurgeon because he and Egas Moniz were the first to perform cerebral (carotid artery) angiography, and I had bought a book authored by them when I was a trainee in London. I was immensely touched because the parcel contained a sweater, which I was allowed to wear, and some books in English to let me pass my time. Professor Lima also wrote a letter in which he said that he was distressed and upset that an innocent person like me was incarcerated by his government. He also said that writing this could put him into some trouble, but he did not care. I wish I had kept that letter; but I was then a young man in a hurry wanting to get along with life. Obviously, he was not a supporter of Salazar and his government, but there was little he could do about it. It was not possible for me to thank him then in the situation I was in, but in 1969 at the combined World Federation of Neurology (WFN) international meeting of neurologists and neurosurgeons in New York, I got a chance to meet him face to face and profusely thanked him for his kindness and his courage.

After 1 month, we were shifted from our dingy prison cell to a slightly better one with some bathing facility, and also a pack of cards and cigarettes, which I passed on to my mates. I also realized that it was not the British but the Egyptians who had intervened on behalf of India when an Egyptian consular officer, Shukri Fouad, turned up to find out how we were being treated. Jawaharlal Nehru and Gamel Abdel Nasser were great friends!

Along with the Egyptian consular officer, the Red Cross and Amnesty International were involved in looking after our welfare and release. I am not aware of the role of each of them, but the most concerned was the Egyptian and Amnesty International, which had highlighted our plight in the press. I should also mention here that one of the persons who raised their voice for my release was the late Dr. Dorothy Russell, a renowned neuropathologist of the London Hospital, who knew me as a registrar in London. After my release from prison, she later wrote in the British Medical Journal: "In December, 1961, Dr. N.H. Wadia, an Indian neurologist, well known to many in England having worked as registrar in two London teaching hospitals, was detained in Portugal for two months in the notorious Caxias prison as a reprisal for the Indian annexation of Goa. He had been forcibly removed from a plane in Lisbon while returning from a neurological congress in South America. The first month was spent in a dungeon with another Indian doctor and three Indian engineers, under conditions of deprivation and squalor. Some improvement followed the intervention of the United Arab Republic (the official intermediary between Portugal and India), the Papal Nuncio, and the International Red Cross. Continued pressure from medical bodies and eminent neurologists in this and other European countries, the United States of America, and Chile helped to hasten Dr. Wadia's release.

"Dr. Wadia's experience focuses attention on the work of Amnesty for the plight of the 'forgotten prisoner.' This Society sent a lawyer to Portugal to help him and others amongst whom there were men and women doctors, of whose imprisonment they had learnt" (BMJ 1962 May 19 [doi:10.1136/bmj.1.5289.1418-a]).

An elderly Indian doctor who came with a cardiac ailment was released at the end of the month on health grounds through the intervention of Red Cross. But the three gold miners and I had to wait another month until Feb. 20, 1962, when we were suddenly told that we were to be set free. No explanation was given. I was taken to a hotel, and the next day I was put on a flight to London, where I was greeted by well-wishers, and soon returned back to Bombay into the arms of my family and a host of admiring students who had come to the airport. (See Figures 1 and 2.)

After my release, I came to know that friends and concerned colleagues in the United Kingdom had heard of our capture and some accounts and protests came in the newspapers there. My mother and brothers – although worried that I had not returned – were not aware for some days of my predicament. This was because there was no fixed date for my return; communications in those days were not easy, and the government of India had not contacted them. They were

Continued on following page

Figure 1. I received a warm welcome home by family and friends on my arrival to Bombay airport in 1962.

PHOTOS COURTESY DR. NOSHIR H. WADIA

Figure 2. Upon my return, I also was greeted at the Bombay airport by admiring undergraduate students of the Grant Medical College and JJ Hospital.

Continued from previous page

shocked when the influential wife of the doctor I met while in prison informed them about my arrest. After this, my brother Jimmy sat in New Delhi for a month pleading with whomever he could, including Nehru, for my release.

Figure 5. This is a photograph of a coaster made by the prisoners, which the prison superintendent gave to my wife and I as a memento of our 1992 visit.

His experience with the government is another story.

I was told that we were not exchanged for Portuguese soldiers held prisoners in Goa. The three miners were released through the intervention of the Pope because they were Catholics and Salazar was also a devout one. I remember that they had asked for a Mass in the prison and were permitted to have it. As for me, I heard from a very reliable source that there was intervention on my behalf by some well-wishers of Indian origin from

WE WERE NEVER SUBJECTED TO ANY TORTURE, BUT SUCH THOUGHTS WERE NEVER FAR AS WE COULD HEAR CRIES OF OTHERS TREATED MORE HARSHLY.

one of the African Portuguese colonies who had the confidence of Salazar. My exchange was for an iconic 400-year-old statue of Jesus Christ enshrined in a Goa church that Salazar wanted. I have never been able to fully confirm this information from any other source, but I am humbled, if it is true.

Somehow, I did not feel bitter or dejected and thanked God it was all over. And soon I was back to my old duties developing my department. Later in the year, I flew to Tokyo to participate in the WFN-organized first Asian Oceanian Congress of Neurology, Oct. 7-10, 1962. As we skirted China in the Air India plane, I wondered if fate would force me to land there, since by then India and China were having major border conflicts. Indeed, war broke out on Oct. 20, 1962!

I must complete this story about Portugal with two very pleasant subsequent experiences, which have left fond memories of that country and its people. The first was a visit with my wife as tourists in 1992. At that time, we gave a courtesy call to the Indian ambassador to whom we had been introduced.

During the conversation, the ambassador asked if this was our first visit to Portugal, and while I was not sure what to say, my wife said, "It is my first visit and his second," and she mentioned my experience of Lisbon in 1961-1962. The ambassador was taken aback and could just recall some details of these events, as he must have been a young officer then. He said he could arrange a visit to the prison, as relations between Portugal and India were very cordial. My wife was most keen to do this, and I was ready as I carried no wounds, which would open. My wife, to whom I was not married when I was a prisoner, could not believe that an innocent person was thrown in a dungeon and not kept in a more acceptable environment under house arrest.

This time, the experience was most pleasant as we were special guests of 'Caxias.' We were driven on a sunny day through the streets of Lisbon, and the prison did not seem too far. We were met by the superintendent of the prison and escorted by a translator who spoke English. The superintendent, a young man who was probably a boy in 1961, was very surprised and asked what crime had I committed when we recalled for him my days of imprisonment. The first area we visited was nothing like the description I had given my wife of where I was initially lodged. This was possibly where I spent the second month. I told the superintendent that I was definitely not in this kind of prison, but in one much worse. He then took us to the back of the large complex, where the remains of the old prison stood, which convinced my wife of my harrowing experience. (See Figures 3 and 4.)

We ended this visit in the superintendent's office with a fine Port wine toast to Portugal and India's friendship. At that time, I was given a memento of a wall plate of the Caxias made by the then-prisoners, and a set of coasters. (See Figure 5.)

The other occasion in which I visited Portugal was in April 1994, when I was invited to participate in the Third International Workshop on Machado-Joseph disease (spinocerebellar ataxia type 3 [SCA3]), sponsored by the WFN. The workshop was on the beautiful island of São Miguel in the Azores, where I presented my research paper on a subject of mutual interest: olivopontocerebellar atrophy with slow eye movements (SCA2).

I met several Portuguese neurologists researching in hereditary ataxias, and told them of my earlier experience in their country and how pleasant it was to be back under totally different circumstances. Not so old as I, their memory of Salazar was rather distant, although they were aware of their country's history.

ON FEB. 20, 1962, WE WERE SUDDENLY TOLD THAT WE WERE TO BE SET FREE, WITHOUT AN EXPLANATION. I WAS PUT ON A FLIGHT TO LONDON THE NEXT DAY.

There are several incidents and anecdotes – some funny and some more serious – that I have not mentioned because they are not relevant to my association with the World Federation of Neurology, but I may expand on them some day.

In the successive years, I involved myself with various research groups and committees of the WFN, and in 1989 I was elected as vice president of the WFN. All this has left very pleasant memories of my 50 years of service with the WFN, which I can look back on in my retirement with contentment.

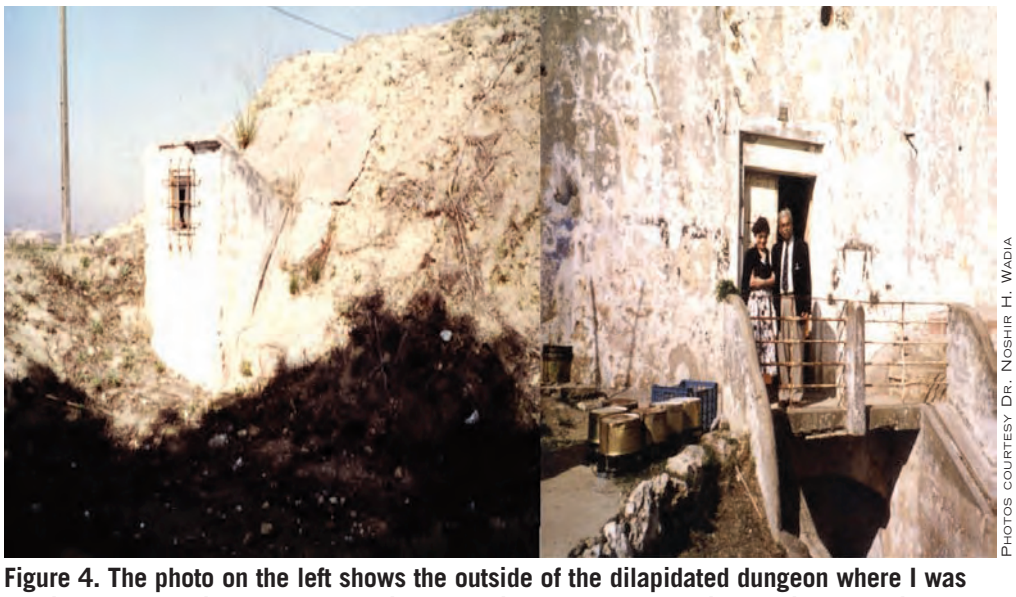
What I have written is entirely from my own memory of events, and there may be errors in small details, as I have never kept diaries of my life. Yet, constant recall over the years has left an indelible imprint somewhat mellowed by advanced age.

Acknowledgments

My thanks are due to the superintendent of Caxias in 1992 for permission to photograph and have photographs taken without reservation, a demonstration of heartwarming cordiality; to the Indian ambassador for arranging the revival visit for my wife and I; and to former WFN President Prof. Johan Aarli for stimulating me to write this account for the first time. I had earlier felt it was too personal to be of interest to anyone, but he believed that this would be worth a mention in his history of the WFN, which he is writing.

Finally, I thank my elder brother, Jimmy, without whose effort to get me released I would have remained longer in Caxias or suffered a worse fate; he also gave me the airport photographs. ■

Figure 3. I visited Portugal with my wife in 1992, where we visited Caxias and met the young superintendent of the prison (on right).



PHOTOS COURTESY DR. NOSHIR H. WADIA

Figure 4. The photo on the left shows the outside of the dilapidated dungeon where I was confined, as seen in 1992. On the right, my wife and I stand outside a prison door in 1992.

FROM THE JOURNAL OF THE NEUROLOGICAL SCIENCES

Residual Symptoms Seen in Many Guillain-Barré Patients at 10 Years

BY JEFF EVANS
IMNG Medical News

Residual disability from Guillain-Barré syndrome that exists 1-2 years after onset may be lifelong, but most patients have minor symptoms and one-third of affected patients are normal 2 years after onset, according to a small, single-center study with 10 years of follow-up.

Most of the acute phase disability that was reported at 2 weeks after symptom onset had decreased significantly by 2 years among the cohort of 29 patients with Guillain-Barré syndrome (GBS). A small minority of patients also continued to improve slightly between 2 and 10 years. Although fully recovered patients described their health-related quality of life as very good, those with some residual symptoms reported fatigue and other subtle changes, such as slower walking speed.

VITALS

Major Finding: Full recovery from Guillain-Barré syndrome occurred in 34% of patients 2 years after disease onset, a rate that stayed the same at 10 years.

Data Source: This was a prospective study of 29 patients who had GBS 10 years earlier.

Disclosures: The study was funded by grants from the Swedish Association of Persons with Neurological Disabilities and the Board of Research for Health and Caring Sciences at Karolinska Institutet. The authors declared having no relevant disclosures.

"This prospective study shows that the residual disabilities at 1-2 years after GBS onset largely continue to persist at 10 years post-onset. This information might help clinicians in providing GBS patients with information about the long-term prognosis, and also in the planning of rehabilitation services," Dr. Anette Forsberg and her colleagues at the Karolinska Institutet, Stockholm, wrote in their report (J. Neurol. Sci. 2012;317:74-9).

Other prospective clinical studies have reported moderate to severe disabilities in 10%-31% of patients at 1 year and in 16%-20% at 2 years. Cross-sectional studies with longer follow-up periods have found residual signs in 31%-48% of patients examined up to 6 years after onset. In the current study, 4 (14%) of the 29 patients had moderate to severe residual disability after 10 years, defined as a GBS disability score of at least 2 (on a scale of 0-7, where 0 means fully recovered).

Dr. Forsberg and her associates identified 42 patients with GBS at eight hospitals in Sweden who had previously taken part in a 2-year, prospective follow-up study (J. Neurol. Sci. 2004;227:131-8). Of the original 42 patients, 35 were alive 10 years later, but 4 declined to participate and 2 could not be found, leaving 29 in the study. At 10 years after GBS onset, these patients had a mean age of 59 years, ranging from 30 to 87 years).

Most improvement occurred in the first 6 months, and was mostly complete in 2 years. While initially none of the patients was normal, 10 (34%) of the 29 became normal after 2 years. This was the same at 10 years, so if a GBS patient did not achieve normality at 2 years, they weren't likely to do so afterward. However, 4 patients continued to improve from 2 to 10 years.

Initially, 18 patients needed assisted ventilation or a wheelchair initially, but only 3 were using a wheelchair at 2 years and only 1 at 10 years.

Paresthesias, prominent in the feet and hands rather than in proximal areas of the extremities, declined over time in the patients from 93% at 2 weeks to 72% at 1 year, 59% at 2 years, and 38% at 10 years.

Facial palsy that was present in 13 (45%) at 2 weeks declined to 24% at 1 year, but 17% saw no further change at 2 and 10 years, "reflecting the poor prognosis of axonal damages to the facial nerve in GBS," the investigators wrote.

At 10 years, health-related quality of life measured by the Sickness Impact Profile (SIP) were significantly worse in those who still had a GBS disability score greater than 1 in the categories of body care and movement, home management, ambulation, and recreation and pastimes. The item most often marked on the SIP at 10 years was 'I walk more slowly,' which was selected by 12 patients. On another measurement of walking ability, the 12-item Walking Scale, 23 patients gave responses indicating limitations in walking (more slowly or less smoothly).

"These results reflect the fact that residual symptoms may be subtle, and therefore measures of physical capacity need to include aspects such as longer walking distances," the investigators wrote.

The patients with a GBS disability score of at least 1 at 10 years had significantly higher mean scores on the Fatigue Severity Scale than did those who had fully recovered. ■

COMMENTARY

'Realistic View' of GBS

When I was a junior neurology resident, I had thought that all patients with Guillain-Barré syndrome (GBS) eventually had a complete recovery, usually in a year or so. With experience, there came a much more tempered view of the disease, but there was an overall sense that once survived, the effects of the disease eventually faded. With even more experience, optimism was further tempered.

This important paper promotes a more realistic view of the prognosis of GBS. Most such studies follow patients for 1 or 2 years and the studies that include larger numbers of patients are cross-sectional. The latter carry obvious biases and can be problematic to interpret. In this study, the prospective follow-up on 29 Swedish patients with GBS treated with intravenous immunoglobulin continued for 10 years. Of these 29, 4 had moderate to severe residual disability at 10 years, while 15 had minor symptoms.

So was my naivete as a resident justified? Yes and no. It is true that most patients improve considerably, but a significant number had permanent deficits, a small number of which were severe. It was true that most improvement occurred in the first 2 years but some took more than that. It would be interesting to speculate on why this would be true – new axonal sprouting which would take a long time to reinnervate, as opposed to remyelination of injured but not permanently damaged axons? Does this imply that there are different pathogeneses of the disease? Would the subset of patients with slow recovery provide clues that may be used in designing neuroprotective therapies?

Alex Tselis, MD, PhD, *is associate professor of neurology at Wayne State University in Detroit, USA, and book review editor for the Journal of Neurological Sciences.*

Cognitive Impairment Seen in Childhood CNS Vasculitis

BY BRUCE JANCIN
IMNG Medical News

BERLIN – Patients with childhood primary angiitis of the central nervous system are at elevated risk for poor cognitive outcome, and the risk is highest by far in the subgroup with small-vessel disease presenting with seizures.

In the years since use of immunosuppressive therapy has become common, mortality among affected children has lessened. "Most children survive. However, in day-to-day clinical practice, it's our observation that what matters most to parents of these children is their long-term cognitive outcome. Parents ask us, 'Will our child attend a regular school? Will our child achieve the same levels of academic performance and social and vocational accomplishments as their siblings?' " Dr. Peter Gowdie of the University of Toronto Hospital for Sick Children said at the annual European Congress of Rheumatology.

He and his coinvestigators sought answers to these questions in their single-center, retrospective, cohort study involving 63 patients with childhood primary angiitis of the CNS (cPACNS) without known premorbid cognitive deficits. Nineteen children had the small-vessel subtype, which is angiography negative and requires brain biopsy for diagnosis. Forty-four had large-vessel disease, which is identifiable on angiography and for which brain biopsy is therefore not indicated.

The median age at diagnosis was 8.1 years, with a median time to cognitive testing of 14.8 months.

Patients with large- and small-vessel cPACNS differed in several key ways in terms of clinical presentation (see chart), as previously noted in other studies.

Neurocognitive testing was carried out using the Wechsler Intelligence Scale for Children (WISC), a comprehensive battery of 10 subtests assessing a variety of domains.

Scores of 85-115 on the full scale IQ portion of the WISC are considered within average range. The majority of children with small-vessel cPACNS – 53% to be exact – scored below 85, which indicates global cognitive impairment. This was twice the rate seen in children with large-vessel disease. The mean full-scale IQ score in patients with small-vessel

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Turkey Program Visits Highlight Africa Initiative

BY WOLFGANG GRISOLD, MD
Cochair, WFN Education Committee

The reports from the coordinators and participants of the Turkish department visit program illustrate the successful cooperation between the Turkish Neurological Society and the World Federation of Neurology, which together established the program within the Africa Initiative.

The template for this initiative has been successfully practiced by the European Federation of Neurological Societies, who have had a department exchange program for many years. The idea is to create a platform for residents and young neurologists to get to know how neurology is practiced in a different country, become familiar with techniques and investigations, get to know other health systems, and, above all, meet other neurologists. This successful program has established connections, collaborations, and research with the remotest places in Europe.

African regions have different needs in regard to neurological services, education, and practice. The WFN exchange program offered African colleagues the opportunity to visit university departments of high standard and internationally renowned teachers in Turkey. The Turkish Neurological Society entirely financed the program, and the WFN organized the exchange, where the new website (www.wfneurology.org) also was useful.

This was an interesting pilot project for Africa and the WFN, which proved:

- There is interest in such a program (nearly all of the 16 applications would have been eligible).
- The program is practicable (from the application to travel and the practical visit).
- It was appreciated and useful for the two participants.

We are thankful for the suggested changes to the program by one of the participants, and all points have merit. The intention at the moment is a short visit and not a specific training content, or a fellowship. These suggestions can be the focus of future department exchange programs, or WFN fellowships.

From my point of view, it was a successful start for an interesting project. I am sure each individual participating in this program will seed the spirit of neurology in his home country and amplify the effect of the training. ■

Forging Relationships

African Neurologists • *from page 1*

EMG, evoked potentials, neurorehabilitation, grand rounds, journal club, case discussions, and outpatient clinic in our department and joined MRI interpretation sessions in the neuroradiology department. The language barrier was resolved with the help of a translator available sitting next to her.

Dr. Zebenigus' presentation on "Medicine and Neurology in Ethiopia" was very informative, interesting, and well attended by the staff members, residents, and medical students.

She was invited to Ankara Training and Research Hospital and Gazi University Neurology Departments where she was able to meet the neurology staff and observe their working environment. She met Dr. Wolfgang Grisold, cochair of the WFN Education Committee, and TNS council members during her visit to Istanbul where she had a brief tour in the historical city during the weekend. She was a highly motivated, knowledgeable, organized, and conscientious physician with excellent command of English. We were all very pleased to have her in our department.

I believe this program established by the WFN gave both sides excellent opportunities to have relations with mutual interests and share insights into their culture and health system. I'm sure Dr. Zebenigus will be helpful to others when she is back.

The TNS supported this program with a strong belief in helping others, the benefit of cultural exchange, peace, and the standardization of neurological care in the whole world. I think the mission has been accomplished and we will be looking forward to having a continuous relationship with Dr. Zebenigus, her colleagues from Ethiopia, and other African countries in the future as well.

DR. TÜLAY KANSU *is professor of neurology at Hacettepe University School of Medicine. She also is the Turkish delegate to the WFN and a former president of the Turkish Neurological Society (2009-2011).*

Dr. Philip B. Adebayo

On March 18, 2012, Dr. Adebayo began a 1-month visit to our department of neurology at Cerrahpasa School of Medicine at Istanbul University.

Philip spent most of his time at our stroke unit, epilepsy division, EEG, and EMG labs, as well as the Doppler lab, sleep unit, and algology/headache clinic, and he attended most of our noon conferences. These conferences varied according to the day of the week (on Mondays – case of the week and overview of the related neurologic condition; Tuesdays – residents' presentation; Wednesdays – journal club; Thursdays – headache and cerebrovascular diseases rounds on alternative weeks; and Fridays – clinicopathological case discussions).

Dr. Adebayo also met with us at weekly neuroradiology interactive meetings on Wednesday mornings. There was always either one of our residents or a medical student who translated the ongoing activities and discussions and he was also informed by faculty members with whom he worked.

Philip gave a presentation soon before his departure at one of our noon meetings, which he titled "Nigeria, Neurology and My Cerrahpasa Experience." We enjoyed his presentation and also learned a great deal about Nigeria and neurology in Nigeria and Africa. He then summarized his activities in the different sections of our department.

Philip is a wonderful person, very modest and hardworking. Everyone in our department liked him very much, from the faculty to our youngest residents, medical students and trainees, as well as secretaries, nurses, and technicians. I believe he will be one of the pioneers of modern neurology in his country and we will hear more of his achievements in the future. We will certainly keep in touch with him and his department.

Finally, the Turkish Neurological Society, through a private benefactor, would like to further support the African initiatives of the World Federation of Neurology by inviting one Kenyan colleague to visit the department of neurology at Cerrahpasa School of Medicine, Istanbul University. ■

DR. AKSEL SIVA *is professor of neurology at Cerrahpasa Medical School, Istanbul University. He is the chairperson of the WFN Standards and Evaluations Committee and is a former president of the Turkish Neurological Society (2005-2009).*

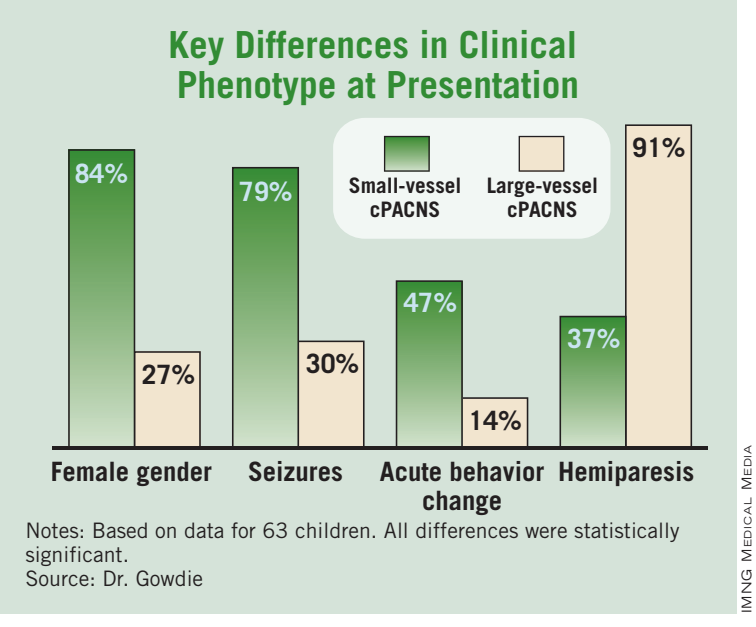
Continued from page 12

cPACNS was 82, compared with 97 in those with large-vessel disease.

The specific cognitive domains where patients with small-vessel disease were disadvantaged were verbal comprehension, with a mean score of 91 compared with 101 in youngsters with large-vessel disease; processing speed, where the difference in mean scores was 83 versus 96; and working memory, on which patients with small-vessel cPACNS had an average score of 81 compared with 96 in those with large-vessel disease.

"Neurocognitive testing is helpful in determining the cognitive burden of cPACNS. Characterization of the cognitive deficits may be helpful in tailoring early rehabilitation interventions," the rheumatologist said.

Patients with large-vessel cPACNS and no seizures had an average Full Scale IQ score of 99. IQ scores were slightly but not significantly lower in those with large-vessel disease who presented with seizures as well as in those with small-vessel disease and no seizures. However, the mean full-scale IQ score was 79 in patients with small-vessel cPACNS who presented with seizures. ■

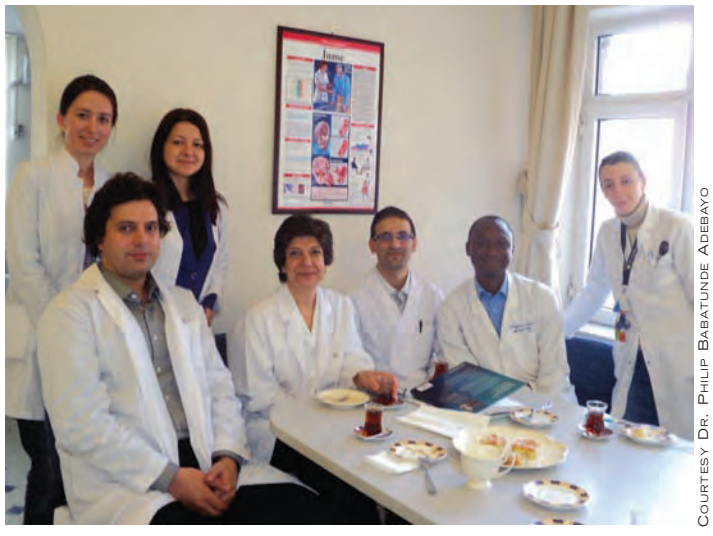


'A Call to Pursue Excellence'

Cerrahpasa • *from page 1*

I arrived at the Cerrahpasa School of Medicine, Istanbul, on March 18, 2012, and quickly settled into my accommodations. My academic program had been sent earlier so I had ample time to revise it, and to plan how I would spend my time. I was warmly received by every member of the neurology department at Cerrahpasa, and I had no problem setting into the clinical and academic programs of the department. (I had to learn some Turkish in the process.)

I spent my Mondays with Dr. Baki Goksan at the stroke outpatient clinic. The clinic saw an average of 20-25 follow-up cases and 5-7 new cases. There also was an in-house carotid Doppler/transcranial Doppler system. The procedure was done every day in clinic. I learned the rudiments of carotid and transcranial Doppler ultrasonography. This clinic also provided the opportunity to interact with other members of the stroke unit, so it was easy to appreciate its stroke protocols. Another stroke outpatient clinic was run by Dr. Birsen Ince on Wednesday. I was there on alternate Wednesdays.



COURTESY DR. PHILIP BABATUNDE ADEBAYO

Here I am (second from the right, sitting) in the company of Dr. Birsen Ince (fourth from the right) and other neurologists.

My Tuesdays and Thursdays were spent in the Epilepsy Unit with Dr. Çigdem Ozkara and Dr. S. Naz Yeni. I joined EEG sessions on Monday (almost always after the stroke clinic since the EEG sessions ended later) as well as on Wednesday. Participation in the EEG sessions has improved my skills in reading EEG, especially with video and sleep EEG, to which I was relatively new. I spent the alternate Wednesdays and Fridays in the electromyography (EMG) laboratory. I also spent 3 days in the sleep unit. The other periods were spent in the general neurology clinic and the movement disorder and headache clinics. I equally attended the Wednesday morning neuroradiology sessions and the daily noon meetings at one of which I gave a presentation titled, "Nigeria, Neurology and My Cerrahpasa Experience."

COURTESY DR. PHILIP BABATUNDE ADEBAYO

In company of Dr. Aksel Siva (in dark jacket) after I gave my presentation "Nigeria, Neurology and My Cerrahpasa Experience."

The memory of this visit will linger with me for a long time. It was an exciting 4-week educative forum for me and a call to pursue excellence. I am beginning to see the impact of my visit already as I review our patients with neurological disorders. I have adapted some of the protocols in Cerrahpasa to our local population in Ogbomoso (especially the headache and the movement disorder protocols). Although our infrastructure challenge may linger for a while and state-of-the art equipment may still be far-fetched, I am of the opinion that well-trained doctors are not negotiable if we must map Africa's way to prominence in neurology. I wish to thank the World Federation of Neurology, the Turkish Neurological Society, and the department of neurology at the Cerrahpasa Medical School for this opportunity. I also wish to thank Dr. Siva and Dr. Derya Uluduz for making my stay memorable. ■

DR. ADEBAYO *is from the neurology unit in the department of medicine at Ladoke Akintola University and Teaching Hospital in Ogbomoso, Nigeria.*

Hacettepe Visit

Building Relationships • *from page 1*

trophysiology laboratory observing single-fiber electromyography (SFEMG), cortical magnetic stimulation, evoked potentials, and routine Nerve Conduction Studies/EMG. I acquired ample experience in the video EEG laboratory and neuroradiology department. I also attended outpatient clinics, grand rounds, journal clubs, and case discussions. A translator was usually available even if the meetings were in Turkish. A brief visit to the neurorehabilitation department and other institutions (Ankara University, Gazi University, and Ankara State Hospital) gave me a broader insight about the advanced level of medical practice in Turkey.

I was given the opportunity to present to the department staff at Hacettepe University as well as Ankara State Hospital in a joint session with Dr. Berna Arda from Ankara University (who visited my department a year ago) on "medicine and neurology practice in Ethiopia," which was highly appreciated and taken with enthusiasm.

My visit was spiced with off–work hour visits of wonderful and historical museums, city parks, open bazaars, and shops in Ankara, which still are fresh memories. I had the privilege of accompanying Dr. Kansu on her meeting trip to Istanbul on the last weekend of my stay, where I met with the executive committee of the Turkish Neurological Society. I had a historic tour of the extraordinary city of Istanbul as well. Although my journey was relatively short, I highly enjoyed being in Turkey and acquired as much new information as possible, which I have already put into practice.

'I AM HOPING THIS IS JUST THE FIRST OF MANY MORE SIMILAR VISITS FOR OTHER FELLOW COLLEAGUES IN AFRICA AND ETHIOPIA IN PARTICULAR.'

I am hoping this is just the first of many more similar visits for other fellow colleagues in Africa and Ethiopia in particular. My recommendations for future visits and visitors, who would make a similar visit, are:

- Provide focused training on one area of interest of the candidate.
- Plan for a longer period of visit – no less than 2-3 months.
- Provide an awarding certificate or letter to the candidate who completed visit.
- Build similar programs in other European countries to help African neurologists.
- Develop programs for European neurologists to visit African university hospitals.

COURTESY DR. MEHILA ZEBENIGUS

In my last week, I accompanied Dr. Tülay Kansu to an executive committee meeting of the Turkish Neurological Society.

COURTESY DR. MEHILA ZEBENIGUS

In the last week of my visit, I met with Dr. Tülay Kansu (left) and Dr. Wolfgang Grisold from the WFN in Istanbul.

COURTESY DR. MEHILA ZEBENIGUS

In my second week, I gave a presentation on "Medicine and Neurology in Ethiopia" to neurology staff and residents.

I am grateful to Addis Ababa University, the head and staff of the department of neurology, and my colleagues at Yehuleshet Higher Clinic for making this visit a reality. ■

DR. ZEBENIGUS *is from the department of neurology in the school of medicine at Addis Ababa University, Ethiopia.*

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