LETTER TO THE EDITOR

Author Reply: Letter about Status Epilepticus as a Presenting Feature

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Keywords: Posterior reversible encephalopathy syndrome, Seizures, Status epilepticus.
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Dear Editor,

I appreciate the author's suggestions and observations; however, most of them are already covered in the manuscript and are standard clinical concepts. The author discussed about the limitation of the study being its small size and retrospective design. Studies on the same topic have been done with somewhat smaller sample sizes, although sample sizes equal to or greater than 30 are often considered to be sufficient.[1,2] As a result, it is unreasonable to regard the sample size of 40 as being small and a limitation for the current study. The retrospective study design followed in this study is very appropriate and has been already discussed in various studies.[1,3]

The author suggested a well-powered study comparing early versus late. Here, the clinical meaning of the word "early" in our context refers to the early detection of posterior reversible encephalopathy syndrome (PRES), which is critical for the prompt initiation of therapy, and normally entails controlling blood pressure and discontinuing potentially harmful medications. Although by definition reversible, subsequent consequences include status epilepticus (SE), cerebral hemorrhage, and massive ischemia infarction which can substantially raise morbidity and mortality.[4] There was a question regarding 6 month follow-up imaging in the institution. Since PRES is characterized by neuroimaging findings of reversible vasogenic subcortical edema without infarction, the clinical presentation is often nonspecific, and its diagnosis increasingly relies on magnetic resonance imaging (MRI) abnormalities consistent with PRES with documented recovery clinically and on repeated neuroimaging.[5] Studies showing six months follow-up.[6] The neurological assessment and MRI reports are important in retrospective clinical investigations, but it is insignificant to emphasize whether the test was performed on-site or off-site. The study followed all the participants, of them seven were telephonically contacted and the remaining 33 participated in physical interviews for follow-up. Regarding the query about the discrepancy between the aims and result of the study, the author should note that the result section in the study has already emphasized several aspects of the clinical context, which is the prime objective of the study. The reason behind 32 patients without status epilepticus not being excluded from further analysis was that the inclusion and exclusion criteria are pre-specified and the same has been followed in designing the study. Author also stated that status epilepticus as the manifestation of PRES is not a new finding rather has previously been described as the first manifestation of PRES but there is an article (not case reports) that states that even though seizures are often a manifestation of PRES, SE as a presenting emergency is not known.[3] Moreover, ours is the first study of its kind, which has been reported from that particular geographical region of India.

The reason behind not ruling out all the differential diagnoses are that the purpose of the study is not to explain the diagnosis but to emphasize the clinical changes experienced by the patients having PRES and its underlying etiology. There was no need to delineate a postictal state and PRES in the 31 patients with seizures and the eight patients with status epilepticus respectively because this is a retrospective study and assessment has been made based on the available records. Regarding the inconsistency of number of patients included in the abstract, the author missed one case of AIDP already mentioned in the manuscript which provides a complete description of 40 cases. The broader classification of the clinical situation can be considered a neurological deficit and the same has been reported since the no of cases are less and complete records on sub-classification are unavailable.

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