Carbamazepine: A Symptomatic Treatment of the Paresthesiae Associated with Lhermitte's Sign

Sir,

I read with great interest the review article on Lhermitte's sign by Khare and Seth.

The sign occurs, inter alia, in multiple sclerosis, in traumatic lesions of the cervical cord, and in subacute combined degeneration. I agree that very few studies are available on Lhermitte's sign and there is need of more research in this particular field. In this current review, treatment with extracranial picotesla range pulsed electromagnetic fields was said to be effective. Neck brace and collar might also be prescribed by physical therapists, and exercises and relaxation technique were claimed to be helpful.

I found that carbamazepine in a rather small dosage had an immediate symptomatic effect on the paresthesiae associated with Lhermitte's sign in three patients with multiple sclerosis. In two of the patients, the symptoms reappeared when the treatment was discontinued. In two cases, the effect of the drug could be reproduced in several short series of treatment and was checked at each examination by letting the patient repeatedly bend his/her head forward in both a recumbent and sitting position. The therapeutic results in my cases resembled those obtained by carbamazepine in connection with the treatment of trigeminal neuralgia and spontaneous paroxysmal symptoms in multiple sclerosis such as painful tonic seizures and paroxysmal dysarthria.

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Nil.

Conflicts of interest
There are no conflicts of interest.

Karl Ekbom
Department of Neurology, Karolinska University Hospital, Huddinge, Stockholm, Sweden

Address for correspondence:
Dr. Karl Ekbom, Department of Neurology, Karolinska University Hospital, Huddinge, Stockholm, Sweden.
E-mail: karl.ekbom@tele2.se

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Bupropion and Iron for Restless Leg Syndrome: Do They Have Efficacy Similar to Ropinirole?

Sir,

I read with interest the study on efficacy and tolerability of ropinirole, bupropion, and iron for the treatment of restless leg syndrome (RLS) reported by Vishwakarma et al. in October-December issue of 2016. The authors have rightly pointed out that the dopamine agonist, ropinirole is considered as the standard treatment of idiopathic RLS (beside pramipexole and rotigotine), at a dose ranging from 1.5 to 4.6 mg in the systematic review and meta-analysis by Aurora et al. Similar conclusions were reached in the meta-analysis by Scholz et al. There is only one randomized, placebo-controlled trial that found bupropion to be efficacious than placebo in RLS at 3 weeks but not at 6 weeks. Although iron therapy has been evaluated in six randomized-controlled trials, the meta-analysis by Trotti et al. found that the evidence is not sufficient to conclude that it is beneficial in RLS. In the current study, the authors have compared fixed-dose bupropion and combination of iron with folic acid, with ropinirole, which is the standard treatment available and acts as an active control. However, the authors have not specified whether this is a superiority or a noninferiority trial; the latter can be conducted with smaller sample sizes.

The authors have recruited 103 patients but presented the data for 90 patients. It is not clear whether the 13 dropouts received treatment and did not complete 6-week follow-up and at which stage they were lost. A CONSORT diagram depicting the flow of participants in the study is desirable, which improves the understanding of the results. Furthermore, in addition to
Letters to the Editor

In the process of randomization and the allocation concealment, it is not clear about the bias in reporting results. Furthermore, from the description, we are neither superior nor equivalent to ropinirole. The treatment of restless legs syndrome and periodic limb movement disorder in adults – An update for 2012: Practice parameters with evidence-based systematic review and meta-analyses: An American Academy of Sleep Medicine Clinical Practice Guideline. Sleep 2012;35:1039-62.

For the primary outcome, i.e., International Restless Legs Scale (IRLS) score, there were significant effect of time, which suggests improvement in all the three groups, and significant group × time interaction, suggesting differences in efficacy between the treatment groups. Post hoc comparison suggested ropinirole be more effective than bupropion and iron and folate combination as shown in Figure 1 of Vishwakarma et al. However, in the absence of control group, it was assumed that both bupropion and iron and folate combination were effective treatment in RLS. In reality, both treatment groups were neither superior nor equivalent to ropinirole, which is considered as standard treatment. In such situations, it is better to report the effect sizes of the differences with 95% confidence intervals and discuss the practical significance of the finding, i.e., reduction in IRLS scores. Furthermore, it was interesting to observe that ropinirole was effective at a dose of 0.5 mg/day, which is much lower than the recommended dose of 1.5–4.6 mg/day.

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Conflicts of interest
There are no conflicts of interest.

Samir Kumar Praharaj
Department of Psychiatry, Kasturba Medical College, Manipal, Karnataka, India

Address for correspondence: Dr. Samir Kumar Praharaj, Department of Psychiatry, Kasturba Medical College, Manipal - 576 104, Karnataka, India. E-mail: samirpsyche@yahoo.co.in

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