Letters to the Editor

Included or not remains unclear from the available description. No objective test (e.g. urinalysis) was employed to rule out concurrent substance abuse, in particular, benzodiazepine use, which has the potential to induce withdrawal seizures similar to alcohol. It has been mentioned that all subjects gave informed written consent to participate in the study; however, some patients had delirium as reported in the paper. From an ethical perspective, a mention must be made of the consent from a legal guardian. Table 1 shows mean time interval between alcohol intake to seizure (19.35 ± 35.94 h) where the standard deviation is quite high compared to the mean. Instead, median and range would have conveyed better information on variance or dispersion from mean.

Finally we strongly disagree with one of the inferences in study discussion ‘14 patients in our study had seizures within 6 h of intake of alcohol. When we analyzed this subgroup we found that 8 patients had no significant withdrawal symptoms and the mean lifetime duration of alcohol intake was significantly lower in them compared with the rest…… Hence this group of patients can potentially be considered to have alcohol induced seizures rather than withdrawal seizures’. From the aforementioned pointers, none is conclusively pointing toward a role of alcohol. A person can have seizures even when there is reduction (not necessarily complete cessation) of alcohol use compared to his usual dose. The absence of withdrawal symptoms may also be due to administration of benzodiazepines given for emergency seizure management. There is mixed and contradictory evidence in the literature regarding the role of alcohol in inducing seizures,[4,5] While the issue may be researched further in a separate study, but the above-discussed findings in a small subset of patients should not be taken to assert the link further.

From a research perspective, the study ventures into an important area. However, it is important to study it using a rigorous methodology and refining the operational criteria for inclusion in the study.

Raman Deep Pattanayak
National Drug Dependence Treatment Centre, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India

For correspondence:
Dr. Raman Deep Pattanayak, Assistant Professor, NDDTC, Department of Psychiatry, All India Institute of Medical Sciences, Ansari Nagar, New Delhi - 110 029, India.
E-mail: drramanddeep@gmail.com

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Seasonal and monthly trends in the occurrence of Guillain-Barre syndrome over a 5-year period: A tertiary care hospital-based study from South India

Sir,

Seasonal variations have not been adequately studied in Guillain-Barre Syndrome (GBS). During our clinical practice, it was observed that there was clustering in the occurrence of GBS during certain seasons and months of the year. We did a retrospective study in our institute, a tertiary care center in South India from June 2008 to May 2013, in the departments of Neurology, Medicine, and Pediatrics to analyze the monthly and seasonal occurrence of GBS. The outpatient and inpatient records of all patients who had presented to our hospital with symptoms of acute flaccid paralysis were reviewed retrospectively from June 2008 to May 2013 with special attention to the time of occurrence with respect to month and season. A diagnosis of GBS was made when the clinical features, electrophysiological findings, and CSF parameters satisfied the Asbury and Cornblath diagnostic criteria.[9] Patients with other causes of acute flaccid quadriparesis like acute transverse myelitis, hypokalemic paralysis, polymyositis, and myasthenia gravis were excluded. The seasons in India were divided as: Summer: March to May; Monsoon: June to September; Post-Monsoon: October to November; Winter: December to February according to the seasonal classification of Indian Meteorological Department.[3]
During the 5-year period, there were a total of 284 patients diagnosed with GBS. The male to female ratio was 1.7:1 (males: 179, females: 105), with age of onset from 5 months to 85 years.

The highest incidence of GBS was seen in the monsoon ($n = 92, 32.39\%)$ and winter ($n = 75, 26.40\%)$. There were 67 (23.59\%) cases in summer and 50 (17.60\%) cases in post-Monsoon [Table 1, Figure 1]. The monthly incidences of the disease were significantly high during January (10.21\%), May (9.15\%), June (9.85\%), November (10.91\%), and December (10.56\%) [Table 2].

This observation can be attributed to the fact that the major preceding infections like gastroenteritis[3-5] and Influenza[6] tend to occur during these seasons and hence increasing the risk of acquiring GBS. The seasonal epidemiology of Campylobacter jejuni gastroenteritis has been studied in different regions of India, and a significant seasonal and monthly incidence have also been shown. The seasonality of Campylobacter species has been studied by Singh et al.,[7] which showed the highest prevalence of C. jejuni in the fecal samples during the rainy seasons and in the month of September.

Similar results were observed season-wise in a study from Pune by Saba et al.,[8] which showed a dual peak in the month of May and October. Studies from in and around Delhi showed influenza virus circulation peaks coincided with rainy and winter seasons.[9] A recent study from South India, which observed the seasonal variation in the clinical recovery of patients with GBS requiring mechanical ventilation, showed increase occurrence of GBS during the months of June to August and December to February, which is consistent with our seasonal and monthly peaks.[10] A comparison of the seasonal trends reported from various Indian studies is given in Table 3.

The main highlight and purpose of undertaking this study is to create public awareness among individuals, families, and the government to be prepared round the year for the treatment and management of GBS, especially during monsoon and winter seasons. However, to strengthen this observation, further large multi-centric studies have to be done in future. To have a country wide registry of GBS would be an ideal step forwards, in knowing the incidence, prevalence, and seasonal trends of GBS.

Thomas Mathew1, Meghana Srinivas1, Raghunandan Nadig1, Ramesh Arumugam2, Gosala Raja Kukkuta Sarma1
Departments of Neurology1, ENT2, St. John’s Medical College Hospital, Bangalore, Karnataka, India

For correspondence:
Dr. Thomas Mathew, Department of Neurology, St. John’s Medical College Hospital, Sarjapur Road, Bangalore - 560 034, Karnataka, India.
E-mail: chakkuthom@hotmail.com

Table 1: Seasonal trends over a 5-year period

| Seasons       | Number of cases over 5 years ($n = \_\_\_\_\_\_\_\_\_\_\_\_) | Percentages (%) | Significance |
|---------------|---------------------------------------------------------------|-----------------|--------------|
| Summer        | 67                                                            | 23.59           | ANOVA        |
| Monsoon       | 92                                                            | 32.39           | F=0.85       |
| Post-monsoon  | 50                                                            | 17.60           | P=0.59*      |
| Winter        | 75                                                            | 26.40           |              |

*not significant

Table 2: Monthly trends in the distribution Guillain Barre syndrome over a 5-year period

| Months   | Number of cases over 5 years | Percentage |
|----------|-----------------------------|------------|
| January  | 29                          | 10.21      |
| February | 16                          | 5.63       |
| March    | 21                          | 7.39       |
| April    | 20                          | 7.04       |
| May      | 26                          | 9.15       |
| June     | 28                          | 9.85       |
| July     | 20                          | 7.04       |
| August   | 20                          | 7.04       |
| September| 24                          | 8.45       |
| October  | 19                          | 6.69       |
| November | 31                          | 10.91      |
| December | 30                          | 10.56      |

Table 3: Seasonal trends from different Indian studies

| Study group          | Summer (%) | Monsoon (%) | Post monsoon (%) | Winter (%) |
|----------------------|------------|-------------|------------------|------------|
| Present study        | 67 (23.59) | 92 (32.39)  | 50 (17.60)       | 75 (26.40) |
| Sharma, et al.[11]   | 27 (41.53) | 19 (29.23)  | 8 (12.30)        | 11 (16.92) |
| Sriganesh, et al.[10]| 52 (33.54) | 40 (25.80)  | 35 (22.58)       | 28 (18.06) |
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Accounting for attitude in a KAP Study: A comment on knowledge, attitude and practice of stroke in India versus other developed and developing countries

Sir,

Went through an article entitled “Knowledge, attitude, and practice of stroke in India versus other developed and developing countries” published in Ann Indian Acad Neurol (2013;16:488-93). [1] The authors need to be congratulated for their effort in touching an important aspect neuroepidemiology related to stroke in India. As we all aware awareness about a medical condition is the cornerstone for planning prevention. By referring to the study as a review, the authors have been honest in their interpretation of the evidence by use of explicit methodology.

A review becomes systematic if it is based on a clearly formulated question, identifies relevant studies, appraises their quality and summarizes the evidence by use of explicit methodology.

The authors rightly talk of attitude toward stroke being an almost unexplored area of research. Most of the KAP studies lack in measuring attitude properly (the second part of a standard KAP survey questionnaire).[2] And if studies make an effort to understand attitude, the efforts are inadequate. This study highlights this fact again. Attitude essentially includes three components:

a. A cognitive or knowledge element,

b. An affective or feeling element, and

c. A tendency to action.[3]

The authors tend to do well with the feeling element of the attitude, but have handle “tendency to action” inadequately. This is also reflected in the statement used by the authors; Indian participants were observed to hold an attitude that stroke could occur without any risk factors, simply being an event associated with senility and hence consultation with health personnel was reportedly low. Further it goes on to add that about more than half of the study participants reported that they did not know the appropriate treatment for stroke. Both these statements actually are an extension of awareness or knowledge component only.

Sunil Kumar Raina
Department of Community Medicine, Dr. Rajendra Prasad Government Medical College, Tanda, Kangra, Himachal Pradesh, India

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