

Disputes & Debates: Editors' Choice

Steven Galetta, MD, FAAN, Section Editor

Editors' note: Smoking cessation and secondary stroke prevention

In response to the editorial "Smoking cessation and secondary stroke prevention" by Boehme, Dr. Munakomi emphasizes that passive smoking, including from secondhand smoke and sidestream smoke, can be risk factors for secondary strokes. Author Boehme agrees that both smoke-free environments and smoking cessation should be promoted in the interest of public health.

Megan Alcauskas, MD, and Steven Galetta, MD
Neurology® 2018;90:860. doi:10.1212/WNL.0000000000005403

Reader response: Smoking cessation and secondary stroke prevention

Sunil Munakomi (Biratnagar, Nepal)
Neurology® 2018;90:860. doi:10.1212/WNL.0000000000005405

The editorial by Dr. Boehme¹ emphasizes the importance of smoking cessation in preventing secondary strokes. One major aspect that needs to be addressed is the risk of sidestream or secondhand smoking. Smokers who quit smoking continue to be at increased risk of future strokes if they remain or work within environments of tobacco smoke. Studies assessing risk of stroke due to smoking result in underestimations if only active smoking, and not passive, is considered. A tobacco smoke-free environment is a more rational approach in minimizing the risks due to the global health hazard rather than just promoting smoking cessation.

1. Boehme A. Smoking cessation and secondary stroke prevention. *Neurology* 2017;89:1656–1657.

Copyright © 2018 American Academy of Neurology

Author response: Smoking cessation and secondary stroke prevention

Amelia Boehme (New York)
Neurology® 2018;90:860–861. doi:10.1212/WNL.0000000000005404

Dr. Munakomi's comment on my editorial¹ brings up a great point: in addition to the risk of stroke due to smoking, secondary and tertiary smoke exposure also increases the risk of stroke. In order to cultivate smoke-free environments, individual smoking cessation is needed in addition to the policies used to create smoke-free environments. While smoke-free policies create public smoke-free environments, they do not address the individual environments within the confines of private environments. If individual cessation is not addressed, people can continue to create private smoking environments where the risk of stroke is increased for not only the people who are smoking, but also others with access to the private environment. Without addressing individual smoking cessation, policies that only address public spaces will not be as effective. In order to be most effective at reducing stroke risk due to the effects of

Author disclosures are available upon request (journal@neurology.org).

smoking, effective approaches would need to entail both individual smoking cessation programs as well as policy changes to facilitate public and private smoke-free environments.

1. Boehme A. Smoking cessation and secondary stroke prevention. *Neurology* 2017;89:1656–1657.

Copyright © 2018 American Academy of Neurology

Editors' note: Teaching NeuroImages: RCVS causing simultaneous convexity subarachnoid hemorrhage and hemimedullary infarction

In their Teaching NeuroImages, authors Selvan and Levine described a patient with reversible cerebral vasoconstriction syndrome (RCVS) presenting with thunderclap headache, normal serum and CSF tests, and convexity subarachnoid hemorrhage and hemimedullary infarct on imaging. Angiography showed a left vertebral artery abnormality and diffuse segmental vasoconstriction. Dr. Ganesh notes that the diagnostic criteria for RCVS require reversal of the angiographic abnormalities within 12 weeks of onset and that follow-up is particularly relevant in this case to assess the progression of the vertebral artery abnormality. Author Selvan relays that subsequent angiography 8 weeks after hospitalization showed no abnormalities and that the patient has remained asymptomatic 2 years after the event.

Megan Alcauskas, MD, and Steven Galetta, MD
Neurology® 2018;90:861. doi:10.1212/WNL.0000000000005407

Reader response: Teaching NeuroImages: RCVS causing simultaneous convexity subarachnoid hemorrhage and hemimedullary infarction

Aravind Ganesh (Calgary, AB, Canada)
Neurology® 2018;90:861. doi:10.1212/WNL.0000000000005406

I enjoyed reading the Teaching NeuroImage by Drs. Selvan and Levine,¹ which demonstrated simultaneous convexity subarachnoid hemorrhage and hemimedullary infarct in a patient with thunderclap headache and focal neurologic symptoms, with tapering of the left vertebral artery and diffuse segmental vasoconstriction on catheter angiography, but otherwise normal serum and CSF tests. I agree with the authors that the most likely diagnosis is reversible cerebral vasoconstriction syndrome (RCVS), and most would probably treat supportively in the clinical setting. However, the proposed diagnostic criteria for RCVS require the demonstration of reversibility of angiographic abnormalities within 12 weeks of onset.² This is particularly relevant in this case to ensure that the vertebral artery abnormality (for example) does not have underlying atherosclerosis, since this could have additional medical (and perhaps interventional) implications for secondary stroke prevention for this patient.³

1. Selvan P, Levine SR. Teaching NeuroImages: RCVS causing simultaneous convexity subarachnoid hemorrhage and hemimedullary infarction. *Neurology* 2017;89:e149–e150.
2. Ducros A. Reversible cerebral vasoconstriction syndrome. *Lancet Neurol* 2012;11:906–917.
3. Markus HS, Larsson SC, Kuker W, et al. Stenting for symptomatic vertebral artery stenosis: the Vertebral Artery Ischaemia Stenting Trial. *Neurology* 2017;89:1229–1236.

Copyright © 2018 American Academy of Neurology

Author disclosures are available upon request (journal@neurology.org).

Author response: Teaching NeuroImages: RCVS causing simultaneous convexity subarachnoid hemorrhage and hemimedullary infarction

Prad Selvan (New York)

Neurology® 2018;90:862. doi:10.1212/WNL.0000000000005458

I thank Dr. Ganesh for the comment on our Teaching NeuroImage.¹ The patient did undergo follow-up diagnostic catheter angiography 8 weeks after hospitalization, which demonstrated no abnormalities. Last follow-up occurred 2 years after the index event and he has had no evidence of further cerebrovascular events. He has also remained headache free.

1. Selvan P, Levine SR. Teaching NeuroImages: RCVS causing simultaneous convexity subarachnoid hemorrhage and hemimedullary infarction. *Neurology* 2017;89:e149–e150.

Copyright © 2018 American Academy of Neurology

Disputes & Debates: Rapid online correspondence

The editors encourage comments on recent articles through Disputes & Debates:


Access an article at *Neurology.org/N* and click on “COMMENT” beneath the article header. Responses will be posted within 3 business days.


Before submitting a comment to Disputes & Debates, remember the following:

- Disputes & Debates is restricted to comments about studies published in *Neurology* within the last eight weeks
- Read previously posted comments; redundant comments will not be posted
- Your submission must be 200 words or less and have a maximum of five references; reference one must be the article on which you are commenting
- You can include a maximum of five authors (including yourself)

Visit the *Neurology*® Website at *Neurology.org/N*

- More article-based content on home pages
- Streamlined menus and navigation
- Enhanced blog sections for specialty areas
- Same experience on desktop, tablet, and mobile devices
- Audio summaries of current issues
- Improved article reading experience; links more evident (pdf, analytics, social media)
- *Neurology*® *Clinical Practice* initiative “Practice Current” global surveys will be accessible across sites

 Find *Neurology*® on Facebook: <http://tinyurl.com/neurologyfan>

 Follow *Neurology*® on Twitter: <https://twitter.com/GreenJournal>

Author disclosures are available upon request (journal@neurology.org).