



Figure 2 High-resolution MRI at the level of the cerebellopontine angle. (A) 3D-FIESTA MR image (three-dimensional fast imaging employing steady-state acquisition) showing vascular contact (long arrow) with the right facial nerve (short arrow). (B, C) Three-dimensional time-of-flight MRA (3D-TOF MRA) showing a vascular loop of the right anterior inferior cerebellar artery (arrow) in the internal auditory canal.

which in turn is produced by the trigeminovascular system in cases of migraine attacks.² On the other hand Cuadrado et al. suggested that potentiation of certain trigeminofacial reflexes could cause HFS during a migraine episode.³ Barahona et al. combined all these hypotheses by proposing that central hyperexcitability phenomena, along with activation of trigeminofacial reflexes due to nociceptive stimuli arriving in the caudate nucleus of the trigeminal nerve, plus the possible compression of the facial nerve caused by the dilation of vessels that are in contact with the nerve, may provoke episodes of HFS during migraine attacks in predisposed patients.¹

We believe that migraine-triggered HFS, like migraine-triggered seizure, could be included among the complications of migraine headaches.⁴ Both central and peripheral mechanisms may be involved in the pathogenesis of this condition.

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Respect for dementia patients' autonomy and the need for interdisciplinary cooperation[☆]

Respeto a la autonomía del paciente con demencia y la necesidad de colaboración interdisciplinar

Dear Editor:

It was with great interest that we read Dr. Álvaro's compelling review on competency in dementia patients,

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published in *Neurología*.¹ Beginning with an overview of the philosophical and legal background of the concept of informed consent (IC), he alerts us to the risk that IC might substitute key elements of doctor-patient interaction and be thought of as a mere legal tool.

Obtaining a patient's IC as a general rule has been investigated as a possible obstacle to routine clinical activity since the requirement first entered into force and up to the present day. Studies cite, for example, the difficulties it poses for research involving patients with dementia.^{2,3} Nevertheless, Lidz, Appelbaum, and Meisel stated in 1988 that the problem was not the doctrine of IC, but rather, the way that doctrine was typically implemented.² Social change was followed by legislative change, and as of the 1990s, Spanish autonomous communities such as the Canary Islands (11/1994), Andalusia (2/1998) and Catalonia (21/2000) had introduced laws providing for informed consent. This current culminated with the enactment of Law 41/2002 for the regulation of patient autonomy and the rights and obligations

regarding clinical information and documentation.⁴ Each of these legal instruments intends to provide a response to a social problem, as they specifically state in their preambles.

We should also point out that a legal framework to shape clinical care relationships is still needed today. Even now, specific practices that are clearly of interest to specialists in dementia, such as the use of physical and pharmacological restraints, vary greatly with regard to prevalence and protocol for use.⁵ Society's and health professionals' concerns about the matter are reflected by the organisation of seminars and the creation of review and consensus statements by such institutions as COMB (College of Physicians of Barcelona).⁵ Legislation on this subject is still being enacted in Spain, as shown by Regional Decree 221/2011 of 28 September, applicable to residential social services in the region of Navarre.⁶ While legislative initiatives like this one may increase the workload of healthcare professionals and be applied from a defensive medicine perspective in certain cases, it is likely that they will also introduce changes in clinical practice that will result in added safety for patients, and increased respect for their rights.

Without overlooking the terminological and conceptual complexity of the word 'competency',⁷ the concept of capacity is crucial to the way medicine is currently practised. The need for all healthcare professionals working with elderly patients to receive training in capacity assessment has been underlined repeatedly, and on an international level.⁸ For this reason, we would like to stress that Álvaro's article contributes to the promotion of relevant data and to homogenising and structuring research on competency in dementia, especially with regard to the increasing importance placed on actuarial valuations⁹ as recommended by the Sitges consensus statement.¹⁰

Capacity, as Álvaro explains, involves all of the higher mental functions, and it is an extremely complex parameter to evaluate.¹ It becomes even more complex if we focus on legal competence (which is also examined in this review). Legislation has established that a medical declaration is required before the decision to incapacitate a person can be made (Article 759 of the Code of Civil Procedure¹¹). In line with the benefits of the multidisciplinary approach described in the literature,¹² we believe that neurology specialists play an unquestionably important role in treating dementia cases,¹ as do other professionals including psychiatrists and psychologists. The forensic medical examiner is a doctor with the legal function of providing expert assistance in courts of law, prosecutors' offices, and the Civil Registrar.¹³ When assisting a judge, the examiner must consider information provided by all the above professionals, other information to which he has access by virtue of his position, and that obtained by direct examination of the allegedly incapacitated person.

Supporting the claim that multiple reports must be evaluated, Moye and Marson⁸ describe assessing capacity as "an emerging area of practice and research", and conclude that further studies examining the relationship between clinical and legal models of capacity, and of the relationship between clinical evaluations and legal decisions, will be needed. The purpose of the assessment is to attend to the individual needs of the patient by identifying any need for protection and preserving his or her rights in areas that are functional. In current practice – which tends to

avoid declaring full incapacitation by limiting protection of the patient to those areas in which he or she demonstrates functional difficulty – concerted interdisciplinary cooperation is needed between healthcare and legal professionals, social policy-makers, and legislators in order to successfully approach the trade-off between autonomy and protection. Cooperative initiatives focusing on this line of action are proliferating in our area. First of all, the Sitges consensus statement¹⁰ led to the establishment of OBSCAC, the observatory for cognitive health, autonomy, and competency, which arose through cooperative efforts between the Spanish Society of Neurology, the General Council of Judicial Powers, COMB, the ACE Foundation of the Catalan Institute of Applied Neurosciences, and Catalunya Caixa's social welfare project.¹⁴

The fact that the topic was addressed in this journal is a reflection of neurologists' current level of interest in providing their patients with complete and quality care and contributing to the current initiatives that promulgate information on the subject of patients' rights.

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Competence in dementia: The unfinished task before us[☆]

Competencia en demencia: tarea de todos por completar

Dear Editor:

I am very pleased that our review of competency in dementia¹ has sparked such interest and comments as expressed in the preceding letter.² In recognising the transcendence of this matter and calling for cooperation not only between neurologists and other doctors, but also between other disciplines, the author highlights precisely the key aspects we wished to transmit. Those aspects are the role of the neurologist working side by side with other specialists, and the need for more detailed study of how to recognise competency in specific situations.

Dementia imposes functional limits on patients, and these limits are precisely what defines the entity. Dementia limits the patient's understanding of decisions, including diagnostic and therapeutic decisions, and their consequences. With this in mind, we will have to establish levels of competence and define protocols and consensus guidelines. Such guidelines must contemplate such common and delicate clinical situations as the use of physical or pharmacological restraints, and the patient's ability to understand the benefits and risks of participation in clinical trials. The author was very correct in mentioning these specific examples.²

Incapacitation is a legal resource intended as a means of protecting the patient, even though the consequences that arise from revoking a person's autonomy may lead us to reject this measure. Establishing incapacity resides with the legal authorities, and not with medical specialties. However, expert testimony, based on the examiner's evaluation, plays a crucial part in the process. Interdisciplinary cooperation must be promoted precisely because the process must involve both doctors and legal figures representing diverse fields. It would be very advantageous to set up and prioritise specific focus groups so as to advance beyond the constraints

of certain valuable documents, including the Sitges consensus statement, which the author of the letter highlights.² In doing so, we must also be very aware of the fact that dementia is an evolving process, and that patients' specific needs depend on phases and situations extending across very wide time frames. In fact, a phase may last more than a decade given a sufficiently early diagnosis. If the patient's situation and specific level of competence and the moment in dementia process are not defined, a framework will have only limited practical applicability.

Through consensus and research, multidisciplinary cooperation will contribute to establishing much-needed precise definitions of the patient's situation and phase of dementia.³ However, even more work is needed with regard to non-clinical aspects of daily life. Examples include the ability to vote among increasingly senile populations in different phases of dementia, or the validity of a patient's risky financial decisions. As a result, the subject has obvious sociological implications which must be recognised. It is very possible that our informed and guided society will also have to opine and decide.⁴

Mass interest in such a complex and vitally important subject is a breakthrough that will benefit everyone involved, including medical and legal specialists, but especially patients with dementia and their families. I would like to thank *Neurología* for providing a forum for this topic.

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