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M.I. Morales-Casado[a,*], N. López-Ariztegui[a], F. Muñoz-Escudero[a], Á. Navarro-Bejarano[b], J.A. Pérez-Matos[a]

[a] *Servicio de Neurología, Hospital Virgen de la Salud, Toledo, Spain*

[b] *Terapia ocupacional, Hospital Casaverde Madrid, Navalcarnero, Madrid, Spain*

* Corresponding author.
E-mail address: mimorales@sescam.jccm.es (M.I. Morales-Casado).

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Spectrum of optic neuromyelitis: psychiatric disorders and suicide risk☆

Espectro de la neuromielitis óptica: trastornos psiquiátricos y riesgo de suicidio

We read with great interest the detailed systematic review ''Do patients diagnosed with a neurological disease present increased risk of suicide?'' by Alejos et al.,[1] recently published in *Neurología*, which addresses the hypothesis that the prevalence of suicide is higher among patients with different neurological diseases, especially those of neurodegenerative origin.

The authors contribute evidence supporting the increased risk of suicide in patients with such neurological diseases as epilepsy, migraine, multiple sclerosis, Alzheimer disease, Huntington disease, and Parkinson's disease. However, neuromyelitis optica spectrum disorders (NMOSD), which have been shown to be strongly associated with the risk of suicide in several communications,[2—5] were not included among the diseases analysed. We recently conducted a prospective study that found a surprisingly high rate of suicide attempts among patients with NMOSD. Six in every 20 patients with NMOSD (30% in our cohort) had attempted suicide at least once over the course of the disease. This rate was significantly higher than in healthy controls.[3]

We showed not only that patients with NMOSD presented more suicide attempts, but also that the risk of suicide itself was greater in this patient group. We believe that suicide should be considered a continuum, from the risk of suicide, including ideation, to planning and finally attempting suicide.

In our study, we detected current risk of suicide in 8 in every 20 patients with NMOSD. We would like to underscore the need to dedicate greater effort to identifying the risk of suicide at the time of diagnosis or of severe relapses with residual disability, since we found that most suicide attempts were made in specific situations over the course of NMOSD progression. However, we did not find a significant association between the risk of suicide and the classification of disability as measured by the Expanded Disability State Scale in our sample of patients with NMOSD.

Assessment of the risk of suicide is well developed in the Mini-International Neuropsychiatric Interview (MINI), a simple, semi-structured interview. We found that current risk of suicide, as measured with the MINI, was positively correlated with current depression, as measured with the Beck Depression Inventory (BDI), but was not always associated with major depressive disorder or another psychiatric diagnosis. Therefore, while suicidal tendencies seem not always to be related with a comorbid psychiatric condition, we believe that the BDI may be a useful tool for detecting depression and current risk of suicide in patients with NMOSD and probably other neurological conditions. The presence of psychiatric comorbidities and suicidal tendencies among patients with NMOSD has been assessed by other researchers, who have obtained similar results to our own.[1,3,4] Like the authors of the study,[1] we would like to highlight the need to evaluate suicidal tendencies in patients with neurological diseases, including NMOSD.

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A.M. Villa*, V. Fernández

Hospital General de Agudos Dr. José María Ramos Mejía, Facultad de Medicina, Universidad de Buenos Aires, Buenos Aires, Argentina

*Corresponding author.
E-mail address: andresmaria@gmail.com (A.M. Villa).

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Single pseudotumour lesion, a rare debut presentation of optic neuromyelitis spectrum disorder☆

Lesión pseudotumoral única, una presentación de inicio infrecuente del trastorno del espectro de la neuromielitis óptica

Dear Editor:

Neuromyelitis optica spectrum disorders (NMOSD) are a group of autoimmune inflammatory diseases of the central nervous system, most frequently affecting the optic nerve and spinal cord. The discovery of aquaporin-4 antibodies (AQP4-ab) has contributed to the understanding of manifestations not affecting these structures, and new diagnostic criteria have been developed to facilitate early, accurate diagnosis, both for seropositive and seronegative phenotypes.[1]

Presentation of NMOSD as a tumefactive demyelinating lesion (TDL) in isolation, without spinal cord or optic nerve involvement, is extremely rare.

We report a case of NMOSD presenting with TDL only, and review similar cases from the literature.

Patient

The patient was a 62-year-old woman with no relevant history who consulted due to a 2-week history of dysarthria, aphasia, and right hemiparesis. A brain MRI study (Fig. 1, series 1) showed an extensive frontotemporal gadolinium-enhancing lesion, suggestive of TDL or an atypical high-grade glial tumour. The results of an 11C-methionine PET/CT study were not indicative of neoplastic origin. Cerebrospinal fluid analysis detected mild pleocytosis (8 cells/mL), normal protein levels (0.51 g/L), absence of oligoclonal bands, and normal cytology and immunophenotyping findings. Spinal MRI and visual evoked potentials yielded normal results. Testing for antinuclear antibodies returned positive results (1/1280), with a pattern of antimitochondrial antibodies, compatible with primary biliary cholangitis. We administered 2 megaboluses of intravenous methylprednisolone (1 g), followed by oral prednisolone and rehabilitation therapy.

Seven months later, after a respiratory infection, the patient presented symptoms of confusion, worsening of the right hemiparesis, and syndrome of inappropriate antidiuretic hormone secretion (SIADH). A brain MRI study (Fig. 1, series 2) revealed additional gadolinium-enhancing lesions, showing a cloud-like enhancement pattern. Indirect immunofluorescence testing for AQP4-IgG-ab returned positive findings. The patient was treated with intravenous methylprednisolone, plasmapheresis, and cyclophosphamide.

Three months later, and after 3 cycles of cyclophosphamide, she presented spinal cord syndrome. An MRI study (Fig. 1, series 3) showed longitudinally extensive myelitis and multiple gadolinium-enhancing lesions. Intravenous methylprednisolone was administered once more, and we added rituximab based on the regular assessment of memory B cells.[3]

The patient remains clinically stable at 36 months of follow-up, after 5 cycles of rituximab; radiological signs have improved considerably.

Discussion

The radiological characteristics of the baseline brain lesion led us to perform differential diagnosis between TDL and atypical glial tumour[4]; however, we subsequently came to suspect inflammatory aetiology due to the detection of antibodies associated with another autoimmune disease (despite the absence of symptoms) and the negative findings of the 11C-methionine PET/CT study to determine possible neoplastic origin. The favourable clinical and radiological response to corticotherapy further supported this diagnostic hypothesis, and we opted not to perform a brain biopsy. Following the second episode, consisting of diencephalic involvement (SIADH), the detection of AQP4-ab, and the exclusion of alternative diagnoses, we diagnosed the patient with NMOSD. This form of onset is extremely rare, although the longitudinally extensive myelitis that the patient ultimately developed is typical of the disease.

Only 15% of patients with NMOSD present brain involvement at onset, with or without associated neurological deficits, and onset with TDL in isolation is extremely rare.[5,6] A literature search identified 4 cases of NMOSD presenting with TDL only.[5,7–10] All 4 patients were women, with a similar age of onset to that of our patient and variable initial symptoms; radiology studies revealed cloud-like enhancement in 2 cases.[2] All 4 patients showed absence of oligoclonal bands, and 3 were positive for AQP4-ab. Two presented multiple relapses during the first month of follow-up. Two patients remained stable after treatment with rituximab, as was the case with our patient (Table 1).

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