of prednisone to 5 mg/48 hours resulted in an elevated blood eosinophil count (> 3000 cells/μL) and acute limb ischaemia in the right leg. We increased the dose to 30 mg/day and started treatment with hydroxycarbamide.

Hypereosinophilia may cause bilateral, symmetrical sensory and motor symptoms affecting the distal part of the limbs; asymmetrical involvement in the form of mononeuritis multiplex is extremely rare.[6] Our patient presented idiopathic HS manifesting as mononeuritis multiplex, with an initially complete response to corticosteroid therapy. Following tapering of the corticosteroid, she presented severe systemic symptoms and required immunosuppresive therapy; this underscores the need for strict monitoring of eosinophil levels and early onset of corticosteroid-sparing immunosuppressive therapy due to the risk of relapse.

Idiopathic HS should be included in the differential diagnosis of mononeuritis multiplex: although the condition is a rare cause of multiple mononeuropathy, it responds well to specific treatment.

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Conflicts of interest

The authors have no conflicts of interest to declare

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Improvement of walking ability in patients with adrenoleukodystrophy treated with fampridine as compassionate use☆

Mejoría de la marcha en pacientes con adrenoleucodistrofia tratados con fampridina como uso compasivo

Dear Editor:

Adrenoleukodystrophy is an X-linked genetic disease caused by a mutation that dysregulates metabolism of very long-chain fatty acids. This leads to a defect in axonal myelination and white matter involvement, with neurological symptoms varying according to the form of disease presentation[1]; in some cases, it manifests with symptoms of spastic paraparesis.[2] Furthermore, it is associated with damage to the adrenal cortex, with subsequent hormonal involvement.

Due to its X-linked inheritance pattern, it predominantly affects boys, although girls may also present a certain degree of involvement, which is generally milder but in some cases it may be as disabling as in boys.[2,3]

The clinical spectrum includes:

- A classic form, with onset during childhood, which clinically presents as learning and behavioural problems with psychomotor developmental regression. It also manifests with visual alterations due to optic atrophy, auditory deficits, and progressive motor impairment, causing spastic tetraparesis that generally leads to dependence within a short period (2-3 years).
- A form with onset during young adulthood (approximately in the third decade of life), known as adrenomyeloneuropathy. It generally manifests as a progressive gait disorder with spastic tetraparesis and sensory ataxia. It may be associated with neurogenic bladder, sexual dysfunction, and occasionally adrenal insufficiency, which may also precede the other symptoms. Psychiatric symptoms, such as depression and psychosis, have also been described. Although it inevitably presents a progressive course, progression is slower than in the childhood-onset form.
- Lastly, in cases of predominantly hormonal involvement, symptoms coincide with those of classic Addison syn-

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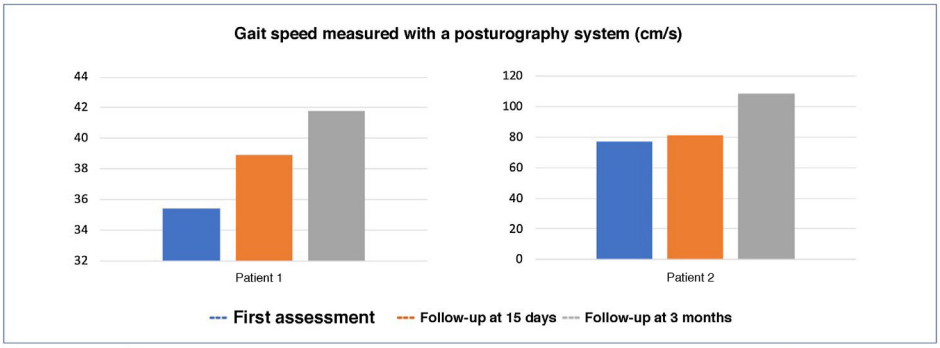

Gait assessment

		Patient 1	Patient 2
T25FW	First assessment	21 s	10.1 s
	Follow-up at 3 months	18.6 s	7 s
MSWS	First assessment	57 s	44 s
	Follow-up at 3 months	51 s	39 s

Patient 1: 26-year-old man
Patient 2: 41-year-old woman

Figure 1 Posturographic study of gait and table of scores on the Timed-25 Foot Walk Test (T25FW) and the Multiple Sclerosis Walking Scale (MSWS).

drome, with adrenal insufficiency being diagnosed in the first years of life, although the majority of patients subsequently present some neurological symptom.

No curative treatment is currently available, although several strategies that may change disease outcomes are being studied.[4–6]

Given the current lack of disease-modifying treatments, symptom progression is inevitable and these patients present high rates of physical dependence.

Considering current evidence on gait improvement in patients with multiple sclerosis and treated with fampridine,[7] we administered the drug as compassionate use in 2 patients with adrenoleukodystrophy and significant gait impairment; both patients gave written informed consent.

Both patients presented adult-onset adrenoleukodystrophy: patient 1 was a 26-year-old man and patient 2 was a 41-year-old woman with weakness in the lower limbs and gait alteration with a spastic paretic pattern. Neither patient presented any relevant history.

Both patients underwent neurological examination, the Timed-25 Foot Walk Test, the Multiple Sclerosis Walking Scale assessment, and a posturographic study (Neurocom Balance Manager System). As reflected by the scales, gait impairment was more pronounced in the male patient, but both patients showed an improvement at day 15 of treatment with fampridine at 10 mg/12 h, which persisted in a follow-up consultation at 3 months (Fig. 1). A noteworthy improvement was also observed in the pyramidal signs, with improvement or resolution of the ankle clonus in the examination. Neither patient presented any adverse reaction.

Subjectively, both patients also reported improved stability when walking and standing. In a follow-up visit at 6 months, scores on the tests performed remained stable.

In the light of these results, and always taking into account the limitations mentioned in the current summary of product characteristics and the administration of the drug as compassionate use, we may consider treatment with fampridine on a case-by-case basis in patients with symptoms of gait alteration with spastic paraparesis, provided that there is no other alternative with proven efficacy. There is a need for further studies assessing fampridine treatment in larger numbers of patients with gait alterations due to spastic paraparesis secondary to diseases other than multiple sclerosis.

Conflicts of interest

The authors have no conflicts of interest to declare. No external funding was received for this study.

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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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