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Letters to the Editor

Letter to the Editor:

We appreciate the excellent review of Carpio, Escobar, and Hauser (1) about the relationship between cysticercosis and epilepsy, and their emphasis on the crucial difference between acute and remote symptomatic seizures (2). This is particularly true when a single cerebral cysticercus granuloma is diagnosed. In our experience (eight cases of single cysticercus granuloma with acute symptomatic seizures), we never observed later epilepsy. In these patients, antiepileptic drugs (AEDs) were discontinued successfully after a few months (3).

However, some aspects related to the prognosis of epilepsy secondary to neurocysticercosis need further comment. This form of remote symptomatic epilepsy is described classically as a "benign condition" easily controlled by AEDs. Although data in support of this are rare, our report on 143 patients with epilepsy due to neurocysticercosis (3) (including eight patients with single cystcercus granulomas and *acute symptomatic seizures,* and 24 with one or more calcifications and a *single symptomatic remote seizure*) with a mean follow-up period of 5 years (finishing in 1993) reinforce this conclusion. At the time of our data analysis, 66% of patients (n = 97) had achieved remission (no seizures in the last 2 years).

Patients not in remission (n = 46) were reevaluated 3 years later. Seventeen of three patients had remitted subsequently; 10 remained uncontrolled, and the condition of 19 was unknown. Assuming that these 19 patients still have seizures, 29 patients (20%) in the series were uncontrolled. The majority of such patients have sporadic minor complex partial seizures (CPS) that have only limited impact on their quality of life. They also live far from our outpatient clinic, which creates difficulties for regular clinical and drug monitoring.

We consider the overall prognosis of all seizures due parenchymatous neurocysticercosis to be as good or better than that of epilepsy in general. The remission rate is high (80%), if follow-up is long enough and medical treatment is continued.

Prospective cohort studies are difficult in developing countries with scarce health facilities, difficult travel conditions, and drugs too expensive for many people. Our experience with neurocysticercosis is from Portugal, a European Union country with rich urban areas and some rural but underdeveloped regions. We have a structured National Health Service (NHS) that provides full medical assistance, shared transportation, and AEDs. In such conditions a coherent and long-term treatment of a chronic condition such as epilepsy is more likely to be successful than in developing countries. Comparisons of results of treatments of a chronic disease that have not taken into account the effects of adverse medical care environments might create problems in interpreting data.

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REPLY

To the Editor:

We thank Monteiro and colleagues for their comments on our article concerning the relationship between neurocystercosis (NC) and epilepsy. We agree that seizures in patients with NC have a prognosis similar to that reported in studies of recurrence after a first unprovoked seizure.

In a clinical trial of treatment of patients with newly identified active neurocysticercosis to evaluate the efficacy of two antihelminthic drugs (albendazole and praziquantel) against each other and against symptomatic treatment alone (1), at 2 years of follow-up, we found no differences in proportion of individual patients who were free of cysts, and the proportion of patients presenting with seizures who were free of seizures (around 60%) was similar in all treatment arms. Not surprisingly, this proportion is similar to that reported (66%) for Monteiro et al. (2).

A recent prospective cohort study to evaluate the risk of seizure recurrence after a first seizure due to NC was performed (3). Twenty-four patients (34%) experienced one or more incidents of seizure recurrence. The cumulative estimate of recurrence was 18% at 6 months, 28% at 12 months, 33% at 24 months, and 48% at 48 months. There was no statistically significant differences in the Kaplan-Meier curves of recurrence between the group who received treatment with albendazole in comparison with the group of patients who only received symptomatic treatment.