First of all, I would like to express my deep appreciation to the Turkish Neurological Society and the World Federation of Neurology for organizing and sponsoring this visit. My special thanks go to the staff and students of the department of neurology at Hacettepe University and particularly to Dr. Tülay Kansu, who not only educated and mentored me, but also made sure that each day was comfortable and memorable.

During my stay in March 2012, I attended different activities in the educational and research settings of the department of neurology at Hacettepe University Medical School, Ankara, during March 1-30, 2012. She was the first woman neurologist in her country. It was quite an experience for her when she landed in snow-covered Ankara, only to then leave when the trees had blossoms at the end of the month.

She attended the activities of EEG, video monitoring, EMG, single-fiber electromyography, and other related topics.

Visits to Turkey Aid African Neurologists

As a part of the World Federation of Neurology’s Africa Initiative, the Turkish Neurological Society offered a 1-month visiting program for neurologists from African countries at Istanbul University Cerrahpasa School of Medicine and Hacettepe University School of Medicine in Ankara. Two candidates among 16 applicants from several African countries were selected by an evaluation committee consisting of members of the WFN Educational Committee and representatives of the Turkish Neurological Society (TNS). Their visit was sponsored by a grant provided from the TNS.

Dr. Mehila Zebenigus

Dr. Zebenigus from Addis Ababa, Ethiopia, visited the department of neurology at Hacettepe University Medical School, Ankara, during March 1-30, 2012. She was the first woman neurologist in her country. It was quite an experience for her when she landed in snow-covered Ankara, only to then leave when the trees had blossoms at the end of the month.

She attended the activities of EEG, video monitoring, EMG, single-fiber electromyography, and other related topics.

A Memorable Learning Experience at Cerrahpasa

To my greatest delight, I received the news of my selection for the World Federation of Neurology Turkish department visit in October 2011, for which I am very grateful. The date of my visit was slated for March 2012. This period I learned would be busy enough to provide a good learning experience for me. Dr. Aksel Siva, together with Dr. Ersin Tan and Dr. Wolfgang Grisold, were quite helpful in providing the necessary documents I needed for obtaining my visa.

Program Ignites Enthusiasm For Building Relationships

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She attended the activities of EEG, video monitoring, EMG, single-fiber electromyography, and other related topics.
Africa’s Neurologist Shortage

The World Federation of Neurology and other international neurological organizations can and should do more to address the lack of specialists in neurology in Africa by assisting African universities in establishing training programs in clinical neuroacide at their medical schools.

Why are there so few specialists in neurology in sub-Saharan Africa? Most African universities have their own medical schools, but the neuroscience curriculum is not consistent. The World Federation of Neurosurgical Societies (WFNS) supported neurosurgery in Africa from the very beginning, but the World Federation of Neurology (WFN) has been more concerned about principles for organizing neurological societies. Sharon Julian of the USA also recently pointed out that neuroscience and related disciplines are subjects feared and shunned by students of medicine and science in Africa.

The main reason for this difference is not in the presentation of curricula for postgraduate education, but more in the differences presented by the WFN and the WFNS. Although the WFNS almost immediately admitted African neurosurgeons into their international system, the WFN required the integration of trained neurologists even before their presence in the national health system. According to the rules, any national society of neurologists with more than five members may apply for membership in the WFN, and can nominate a delegate with a voting right to the Council of Delegates. WFN membership is therefore restricted to national neurological societies comprising qualified neurologists.

However, in 2006, the Council of Delegates concluded that the WFN should be inclusive rather than exclusive in accepting membership applications. It is a part of the mandate of the WFN’s Africa Initiative to monitor the status of neurology training in sub-Saharan Africa. The Africa Initiative therefore seeks to address the special problems faced by countries on the African continent.

Let me use this occasion to thank the Turkish Neurological Society for making this possible, and the WFN Education Committee for their work. There were 16 applicants from various countries, and two of them have been selected. Philip Babatunde Adebayo from Nigeria visited at Cerrahpasa, and Mehila Zebe-nigus from Ethiopia at Hacettepe. I am impressed by what I have read, both the excellent preparatory work made by the Turkish colleagues, and the presentations of modern neuromedicine made visible to the guests.

Continued on following page

WFN Is a Regional Organization

The WFN is an integrated part of a network formed by the WHO, the coordinating authority for health within the United Nations, as well as by governmental and nongovernmental health administrations. It is important for the WFN, with its geographical and regional programs, to operate within the geography of the WHO, whose structure serves as a model for regionalization of neurology and other specialty-related organizations.

The WHO is not structured according to the clinical specialties in medicine. It is a governmental organization with a main responsibility for public health, so its member nations are grouped into six geographical regions (the African, American, South-East Asian, European, Eastern Mediterranean, and Western Pacific regions). Some nations have been assigned to regions outside their traditional geographic area. Algeria is a part of the WHO African region and not of the Eastern Mediterranean region, whereas Morocco, Tunisia, Libya, Egypt, Ethiopia, Sudan, and Somalia are outside the WHO African region. Each WHO region has its own regional office; in Brazzaville, Congo, for the African region; in New Delhi, India, for the South-East Asian region; in Washington, DC, USA, for the American region; in Copenhagen, Denmark, for the European region; in Cairo, Egypt, for the Eastern Mediterranean region; and in Manila, Philippines, for the Western Pacific region.

The WFN regional system is based upon the WHO structure. There are two main structural differences from the WHO. The WFN found it practical to have one North American and one Latin American region because neurology is so well developed in the Americas, and also for linguistic reasons. The WFN Asian-Oceanian Region comprises the South-East Asia and Western Pacific WHO regions.

The WHO South-East Asia Region comprises Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor Leste. The WHO Western Pacific Region is huge, with approximately 1.6 billion inhabitants and nearly one-third of the world’s population.
The digital age is proving more revolutionary than the re-invention of the printing press over half a millennium ago. It can connect individuals instantly across the globe in different visual and auditory forms and it allows a quality and speed of exchange of communications unprecedented by any previous medium.

One of the first priorities of the current administration was to upgrade the World Federation of Neurology (WFN) and make its website more dynamic. It is increasingly being used as a medium of providing and exchanging information. \textit{World Neurology}, our bimonthly publication, is about to go digital, according to the decision of the new editor in chief, Johan Aarli.

The advantage of the printed version is that it is easy to scan and to carry in all sorts of situations. On the other hand, it is becoming increasingly expensive to print and distribute the printed version, and there is a delay between the completion of the content and its delivery.

The online version offers faster communications and access to features that are impossible to provide in a printed version, such as videos. The transition is likely to take place this year.

The activities of the WFN have increased considerably during this administration and have therefore required enhanced infrastructure and support. In a meeting of the Trustees in February of this year, it was decided that there is an advantage in keeping the London office. However, this will be supplemented by hiring help from professional organizations for particular activities, such as enhanced technologies.
WFN Seeks Officer Nominations for 2013 Elections

On ballot: President, First Vice President, Secretary-Treasurer General, and Elected Trustee.

In accordance with the Memorandum and Articles of Association of the World Federation of Neurology, the election of three new officers and one new Trustee, as shown below, must take place at the Annual General Meeting of the Council of Delegates during the World Congress of Neurology in Vienna, Sept. 21-26, 2013.

The officer and Trustee positions are the following:

• President (to take up office starting Jan. 1, 2014)
• First Vice President (to take up office starting Jan. 1, 2014)
• Secretary-Treasurer General (to take up office starting Jan. 1, 2015)
• One Elected Trustee (to take up office starting Sept. 22, 2013)

Candidates for President and First Vice President will be required to formulate a statement of their goals and objectives for the organization, which will be published.

If you wish to propose a candidate for any of these posts, please be in touch with either your national society or WFN Delegate (whose name appears on the WFN website: www.wfneurology.org).

Names of those who are willing to serve and who receive the official support of their national society must arrive at the WFN London headquarters office by Nov. 16, 2012, to enable the Nominating Committee to consider them at a meeting to be arranged.

All admissions reviewed will be scrutinized by the Nominating Committee according to the Guidelines that are published on the WFN website. The names of candidates will be published in World Neurology and on the WFN website at least 6 months before the date of the election. Additional nominations may be submitted by five or more Delegates at least 30 days before the AGM.

All submissions should be sent to:
The WFN Nominating Committee
c/o Keith Newton
Executive Director
WFN London Office
Hill House, Heron Square
Richmond, Surrey, TW9 1EP
United Kingdom

There will be a degree of overlap between old and new administrations in two ways: The term of office of the current Secretary-Treasurer General will continue until Dec. 31, 2014, and two of the three Elected Trustees are already in post at the time of the Congress will also continue to hold office, for 1 and 2 years, respectively.

Meeting Report

Nairobi Symposium Brings African Neurologists Together

BY EVELYN SIPIDO AND ERICH SCHMUTZIARD, MD

Following 4 years of successful Regional Teaching Courses in sub-Saharan Africa, the World Federation of Neurology, the European Federation of Neurological Societies, and the International Brain Research Organization put together a 1-day symposium in Nairobi, Kenya, on June 20, 2012. It met with great success and requests for mulitday programs in the future.

The symposium took place at Aga Khan University Hospital and was held in conjunction with the first African Epilepsy Congress, which also took place in Nairobi during June 21-23, 2012.

The symposium was attended by 70 neurologists, neurologists in training, interns, and other physicians, representing 15 African countries.

Contributions from the three organizations made it possible to invite and sponsor a number of trainees from the neighboring countries to Kenya to attend the symposium. All the invited neurologists in training were specifically recommended by the head of their local departments of neurology.

The trainees who attended the symposium included Dr. Tafa Samson Alemayehu (Ethiopia), Dr. Jenala Mphasto Njirom’madzi (Malawi), Dr. Natalie Govender (South Africa), Dr. Haoua O. Sidibe (Senegal), Dr. Patent Luoga (Tanzania), Dr. Rita Atugonza (Uganda), and Dr. Clarence Chiuba (Zambia).

African colleagues and students chose the focus points of the program, which were multidisciplinary approaches to pediatric neurology and neuroepidemiology in sub-Saharan Africa. Here are some highlights of speakers’ presentations:

• Jo Wilmshurst (South Africa) spoke about neurological complications of HIV in children, in particular, in Cape Town. She said that the earlier children with HIV are diagnosed as being neurologically and neurocognitively impaired, the better the prospects they may have for treatment and prognosis.
• Richard Idro (Uganda) discussed cerebral malaria and its complications, including neurocognitive deficits, language and language development impairment, epilepsy, and dropping out of school.
• Pauline Samia (Kenya) discussed cerebral palsy and its management, delineating very clearly how it was possible to do so within an African community and proving that many therapeutic approaches are possible even in resource poor countries.
• Simon Heales (United Kingdom) addressed neurometabolic disorders in children, concentrating on pyridoxine deficiency and folate deficiency.
• Amadou Gallo Diop (Senegal), the WFN delegate to the symposium, provided insight into the training and care for populations living far from capital cities and health care access in sub-Saharan Africa by discussing the Senegalese experience of so-called neurocaravans. The neurocaravan approach has the motto “bring the doctor/specialist and the medicine to the people” and not vice versa.
• Jenala Mphasto Njirom’madzi (Malawi) concluded the morning session with an extraordinary clinical case presentation from Malawi about adrenoleukodystrophy.
• Erich Schmutzhard (Austria) talked about the prevalence and incidence of primary headache in sub-Saharan Africa, highlighting the importance of tension-type headache and migraine with and without aura, even in the health care of rural sub-Saharan Africa.

Attendees especially thanked Ms. Evelyn Sipido for her organizational work toward the success of the symposium.

Ms. Sipido is a liaison officer to the European Federation of Neurological Societies in Florence, Italy. Dr. Schmutzhard is deputy director of the department of neurology and head of the neurointensive care unit at University Hospital Innsbruck, Austria.
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Neurological Pioneers, Admirers Across the Atlantic

During the last quarter of the 19th century, both in the United States and in France, the field of neurology emerged as an autonomous medical specialty. The most internationally celebrated university professor was Jean-Martin Charcot, whose neurological school at the Salpêtrière Hospital in Paris became the prototypic model for future programs worldwide.

Along with William A. Hammond, Charcot’s major American contemporary was Silas Weir Mitchell. Charcot and Mitchell interacted at multiple intellectual levels, and though their personal contact was modest, they followed each other’s careers closely, cross-referencing one another, usually with respect and sometimes with antagonism. They shared several neurological interests and developed similar philosophical approaches to neurology.

Charcot never visited the United States, but Mitchell voyaged to Paris as a student and later in 1873 and 1875. Whether or not he actually met Charcot in 1873 – or simply attended public lectures – is unclear, but in 1875, he specifically sought out Charcot and his increasingly well-known neurological service at the Salpêtrière. The visit was peculiar, almost theatrical, for Mitchell arrived, not as a colleague, but as an anonymous patient, suffering from overwork. His student recounted the event:

“Charcot examined him and gave a few simple directions, and then turning to him asked where he was from. Mitchell told him he was from Philadelphia. Then Charcot said: ‘You have a man in Philadelphia who knows more about run-down nervous conditions than anyone else I know of, and I will give you a letter to Dr. S. Weir Mitchell, whom you must consult.’ The situation was so ludicrous that Mitchell laughed, and when Charcot asked him what he was laughing about, Mitchell handed him his card.”

In several areas of neurological research, Charcot and Mitchell interfaced. Charcot alluded to Mitchell’s “Injuries of Nerves and Their Consequences” as a “remarkable work,” and Mitchell cited Charcot’s observations on phantom limbs following amputation, suggesting that these cases spoke both to neuropathology as well as neuropsychology.

To contrast with these examples, there are occasional examples reflecting a less congenial spirit on Mitchell’s part. Most examples concerned issues of French vs. American priority in original clinical descriptions. Writing about neuropathic arthropathies, most often seen in tabes dorsalis, Mitchell commented:

“The history of spinal arthropathies is well told by Charcot. ... The history of this subject is somewhat interesting, and the more so, because to an American physician belongs the long-forgotten credit of the first discovery that ‘an obvious spinal cause may produce a rheumatism.’ The quotation is taken from the second paper on rheumatism by my father, the late Dr. John K. Mitchell.”

In fact, Mitchell’s condemnation was poorly founded, and he apparently read French less well than Charcot read English. In 1868, Charcot had alluded to the senior Mitchell, calling specific attention to his observation on joint affections in the context of “caries of the spine with compression of the spinal cord.” In several ways, Charcot and Mitchell helped to lay foundational philosophies that guided the development of early international neurology and specifically marked the French and American schools. First, both men were strong advocates of clinical medicine as the pillar of neurology. In contrast to the growing Prussian emphasis on laboratory science, Charcot and Mitchell held to the principle that neurological advances must always begin and end with clinical analyses. In addition, Charcot and Mitchell taught their neurological students the fundamental element that drives a physician toward medical advances. Reflecting on a patient with amyotrophic lateral sclerosis, for which he acknowledged his impotency to treat, Charcot commented to his students:

“Let us keep looking, in spite of everything. Let us keep searching. It is indeed the best method of finding, and perhaps, thanks to our efforts the verdict we will give to such a patient tomorrow will not be the same as that we must give today.”

More succinctly, Mitchell expressed a similar sentiment by describing the following trait of true physicians: “Not to know surely is to them a form of unhappiness.”

References

Peter J. Kosshier, MD, PhD, is the editor of this column. He is a neurologist in the department of neurology at the Atrium Medical Centre, Heerlen, the Netherlands. Visit his website at www.neurohistory.nl.
First Neurology Certificate Course in Kabul a Success

Attendees of the first Neurology Certificate Course in Kabul, Afghanistan, praised the interactive program that was organized in collaboration with the Afghanistan Ministry of Public Health, Aga Khan University Programs in Afghanistan, and the French Medical Institute for Children, Kabul.

I and Dr. Mughis Sheerani, another senior neurologist from Aga Khan University in Karachi, Pakistan, conducted the course during May 20-24, 2012; the course was funded by an educational grant from the World Federation of Neurology.

The Ministry of Public Health circulated information about the course on a poster to all major medical centers and universities in Afghanistan and on the Internet. Of more than 70 physicians who applied for the course, 40 (including 5 women) were selected based on previous training and interest in neurology, and 14 (including 4 women) participated in the course. These included internists, family physicians, psychiatrists, neurologists, neurosurgeons, pediatricians, and trainees at various hospitals.

The 5-day course had an interactive program covering all important topics in neurology, including neurological history and examination, brain and spine imaging, stroke, epilepsy, headache, movement disorders, and CNS infections. The course also included case presentations from local participants. All participants received course material in CDs, including copies of all presentations and a book in neurology.

The educational value of the course was measured through the amount of knowledge participants gained since taking a pretest before the start of the course, according to a posttest taken at the end. Dr. Najeeb Sikander, a neurosurgeon at Ibn Sina Emergency Hospital in Kabul, said that “this was the best course I have ever attended. It will certainly help us in treating neurological disorders according to international standards.”

Dr. Abdul Wahid Sabet, program director of the pediatrics residency program at the French Medical Institute for Children, and associate professor at Kabul Medical University, said, “This course has really changed our perception of neurology and current neurology practice in Afghanistan. I feel like a neurologist after participating in this course.”

The chief guest, Dr. Ihsanullah Shahir, dean of the Medical College at Aga Khan University, said, “This is a superb contribution and I am so glad to see that through the outstanding efforts of AKU faculty, AKU is making such meaningful contributions towards capacity building in areas of dire need in Afghanistan.”

Dr. Parvez Nayani and Dr. Mohammad Wasy.

A group photo of course participants with facilitators and chief guest Dr. Ihsanullah Shahir (front, center, black coat, no tie) in the courtyard of the French Medical Institute for Children, Kabul. To the right of Dr. Shahir is Dr. Mughis Sheerani (blue coat and blue striped tie) and to the left is Dr. Parvez Nayani and Dr. Mohammad Wasy.

A view of the course participants at the French Medical Institute for Children conference room in Kabul. The 5-day course had an interactive program covering all important topics in neurology, including neurological history and examination, brain and spine imaging, stroke, epilepsy, headache, movement disorders, and CNS infections.

Calendar of International Events

2012

16th Congress of the European Federation of Neurological Societies
September 8-11, 2012
Stockholm, Sweden
www.efns.org/efns2012

Asia Pacific Stroke Conference 2012 (APSC2012)
Sept. 10-12, 2012
Tokyo, Japan
www2.convention.co.jp/APSC2012/index.html

10th European Congress on Epileptology (ECE)
September 30 – October 4, 2012
London, UK
www.epilepsylondon2012.org

28th Congress of the European Committee for Research and Treatment in Multiple Sclerosis (ECTRIMS)
Oct. 10-13, 2012
Lyon, France
www.congress.ch/ectrims2012

8th World Stroke Congress (WSC 2012)
October 10-13, 2012
Brasilia, Brazil
www2.kenes.com/stroke/Pages/Home.aspx

2013

International Headache Society (IHS):
International Headache Congress
June 27-30, 2013
Boston, Mass., USA
www.americanheadachesociety.org/events/2013_international_headache_congress/

XXI World Congress of Neurology
Sept. 21-26, 2013
Vienna, Austria
www2.kenes.com/wcn/Pages/Home.aspx
Family History Tops Parkinson’s Disease Risk Factors

Some risk factors were associated with reduced odds of disease, such as smoking and coffee drinking.

BY MITCHEL L. ZOLER
IMNG Medical News

A family member with Parkinson’s disease confers the strongest risk for developing the disease, according to findings from the largest and most comprehensive systematic review and meta-analysis of Parkinson’s disease risk factors suitable for screening in primary care.

People with a first-degree relative with PD had a more than threefold higher odds for developing PD themselves, compared with those without an affected first-degree relative, based on a meta-analysis of data from 26 case-control studies, and people with any relative with PD had a 4.5-fold greater odds, according to data collected in 19 case-control studies. Dr. Alastair J. Noyce and his associates reported (Ann. Neurol. 2012 July 10: doi: 10.1002/ana.23687).

Dr. Noyce, a researcher in the Institute of Neurology, University College London, and his colleagues identified 202 English-language articles published during 1966-March 2011, of which 173 made it into the meta-analysis. Included studies involved several hundred thousand patients in cohort studies, and several tens of thousands in case-control studies.

The new review and analysis used “an extensive search of observational studies to calculate effect sizes of multiple risk factors for PD,” the study authors wrote.

The meta-analysis found 19 risk factors that significantly linked with an altered risk – increased or decreased – for future development of PD, and assessed 11 additional factors that did not show a statistically significant link to PD. Following family history of PD, other strong associations identified in the meta-analysis included:

- Family history of tremor, which boosted the odds for development of PD 2.7-fold, based on results from 10 case-control studies.
- Head injury, a risk factor associated with a 58% greater odds in 19 case-control studies.
- Mood disorder, another early symptom, which was associated with a 2.3-fold greater odds for PD, based on data from one case-control and one cohort study.
- Constipation, considered an early symptom, which was associated with a 2.5-fold greater odds for PD, based on data from one case-control and one cohort study.
- Mood disorder, another early symptom, which was linked to an 86% higher odds of PD, based on data from 11 case-control and 2 cohort studies.
- Pesticide exposure, a risk factor that was linked to a 78% higher odds, according to data from 36 case-control and 2 cohort studies.
- Head injury, a risk factor associated with a 58% greater odds in 19 case-control studies.
- Constipation may correlate with brainstem involvement, an early effect of PD, the authors wrote.

The analysis identified four other risk factors that were linked to an increase in the odds of developing PD of less than 50% but still reached statistical significance: rural residence (43% greater), beta-blocker use (28%), farming or agricultural work (26%), and well water use (21%).

The remaining eight significant risk factors were all associated with reduced odds for PD.

Leading this category was smoking. Current smokers had 56% lower odds, compared with never-smokers, based on data from 26 case-control studies and 7 cohort studies. People who had ever smoked had a 36% reduced odds compared with never smokers, and past smokers had a 22% reduced odds. Other protective factors were coffee drinking, linked to a 33% drop in odds; hypertension, linked to a 26% reduction in odds; use of non-steroidal anti-inflammatory drugs, associated with 17% lower odds; and use of calcium channel blockers and alcohol, each of which was linked to 10% reduced odds.

The analysis failed to find significant links between development of PD and other proposed risk factors or protective agents, including oral contraceptives, surgical menopause, hormone-replacement therapy, aspirin, acetaminophen, statins, or a history of diabetes.

Predictors of Impulsivity Disorders in Parkinson’s Discovered

By M. Alexander Otto
IMNG Medical News

NEW ORLEANS – Dopamine agonist-induced impulse control disorders may be more likely in Parkinson’s disease patients who smoke, drink, or consume caffeine, according to the first prospective cohort study of the problem.

Major Finding: The peak dose of dopamine agonists was higher among Parkinson’s disease patients on dopamine agonists who developed impulse control disorders than it was in patients without the disorders (median, 300 vs. 165 levodopa equivalents).

Data Source: This is a prospective cohort study of 46 Parkinson’s disease patients on dopamine agonists.

Disclosures: The study was supported by the Parkinson’s Disease Foundation. Mr. Bastiaens said that he had nothing to disclose.

“We found a number of interesting things” when the 18 patients (39%) in the study who developed an impulse control disorder (ICD) were compared with the 28 who did not, said lead author Jesse Bastiaens, a medical student at Cornell University, New York.

The patients had a higher baseline prevalence of caffeine use (100% vs. 67%; P = .007), lifetime prevalence of cigarette smoking (44% vs. 14%; P = .04), and cumulative exposure to both caffeine (72 vs. 38 cup-years; P = .04) and cigarettes (median 2 vs. 0 pack-years; P = .07). There was also a nonsignificant trend towards a higher baseline prevalence of alcohol use.

At baseline, patients with an impulse control disorder also had a greater prevalence of motor complications (61% vs. 18%; P = .01) and lower baseline validated Hoehn and Yahr Scale scores (mean 1.6 vs. 1.9; P = .05), despite comparable total Parkinson’s disease (PD) drug use in both groups (median, 150 levodopa equivalents in both groups).

Impulse control disorder patients had higher peak-dopamine agonist (DA) doses (median, 300 vs. 165 levodopa equivalents; P = .03) but no significant differences in DA treatment duration or cumulative exposure.

“The risk of ICDs [impulse control disorders] in PD is related to both patient-specific factors and peak dopamine agonist dosage,” said Dr. Ronald Pfeffer, vice chair of the department of neurology at the University of Tennessee, Memphis, who moderated Mr. Bastiaens’ presentation.

Patients who developed an impulse disorder did so after a mean treatment duration of 23 months (range, 3-114 months). Age, age of PD onset, sex, depression, anxiety, and other factors were not predictive.

None of the 46 patients (all outpatients) had previous histories of impulse control disorders, and none were described in Parkinson’s patients.”

The risk of impulse control disorders in PD is related to both patient-specific factors and peak dopamine agonist dosage.

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ELSEVIER
Serving the WFN: A Neurologist Remembers Caxias

This is the second and final part of Dr. Wadia’s remarkable story about his imprisonment in Portugal.

I was clear that we were in a desperate situation, and I began preparing myself for a long stay in Caxias. I worried about what was happening at home to my family, my friends, and my department, which I had so carefully nurtured.

We were never subjected to any torture, but such thoughts were never far as we could hear cries of others who were being treated more harshly, and maltreatment of hostages in totalitarian regimes was always well known. I could not interact in any way with the outside world, as we were not allowed to write or have any contact with the outside world.

We were never subjected to any torture, but such thoughts were never far as we could hear cries of others who were being treated more harshly, and maltreatment of hostages in totalitarian regimes was always well known. I could not interact in any way with the outside world, as we were not allowed to write or have any contact with the outside world.

But the threat of more serious problems could be heard outside our cell to warn about our arrival. The lawyer was taken aback when I spoke in a local language, Marathi, but was delighted to hear it. He gave me his name and said he had been in and out of this prison over many years, having been captured for dissidence in Goa and abroad.

By Noshir H. Wadia, MD

Dr. Wadia is emeritus director of neurology at Jaslok Hospital and Research Centre, Mumbai, India.

In 1962, the United Kingdom had heard of our capture and some accounts and protests came in the newspapers there. My mother and brothers – although worried that I had not returned – were not aware for some days of my predicament. This was because there was no fixed date for my return; communications in those days were not easy, and the government of India had not contacted them. They were...
shocked when the influential wife of the doctor I met while in prison informed them about my arrest. After this, my brother Jimmy sat in New Delhi for a month pleading with whomever he could, including Nehru, for my release.

During the conversation, the ambassador asked if this was our first visit to Portugal, and while I was not sure what to say, my wife said, “It is my first visit and his second,” and she mentioned my experience of Lisbon in 1961-1962. The ambassador was taken aback and could just recall some details of these events, as he must have been a young officer then. He said he could arrange a visit to the prison, as relations between Portugal and India were very cordial. My wife was most keen to do this, and I was ready as I carried no wounds, which would open. My wife, to whom I was not married when I was a prisoner, could not believe that an innocent person was thrown in a dungeon and not kept in a more acceptable environment under house arrest.

This time, the experience was most pleasant as we were special guests of Caxias. We were driven on a sunny day through the streets of Lisbon, and the prison did not seem too far. We were met by the superintendent of the prison and escorted by a translator who spoke English. The superintendent, a young man who probably was a boy in 1961, was very surprised and asked what crime had I committed when we recalled for him my days of imprisonment. The first area we visited was nothing like the description I had given my wife of where I was initially lodged. This was possibly where I spent the second month. I told the superintendent that I was definitely not in this kind of prison, but in one much worse. He then took us to the back of the large complex, where the remnants of the old prison stood, which convinced my wife of my harrowing experience. (See Figures 3 and 4.)

We ended this visit in the superintendent’s office with a fine Port wine toast to Portugal and India’s friendship. At that time, I was given a momento of a wall plate of the Caxias made by the then-prisoners, and a set of coasters. (See Figure 5.)

The other occasion in which I visited Portugal was in April 1994, when I was invited to participate in the Third International Workshop on MachadoJoseph disease (spinocerebellar type 3 [SCA3]), sponsored by the WFN. The workshop was on the beautiful island of São Miguel in the Azores, where I presented my research paper on a subject of mutual interest: olivopontocerebellar atrophy with slow eye movements (SCA2). I met several Portuguese neurologists researching in hereditary ataxias, and told them of my earlier experience in their country and how pleasant it was to be back under totally different circumstances. Not so old as I, their memory of Salazar was rather distant, although they were aware of their country’s history.

There were several incidents and anecdotes—some funny and some more serious—that I have not mentioned because they are not relevant to my association with the World Federation of Neurology, but I may expand on them some day.

In the successive years, I involved myself with various research groups and committees of the WFN, and in 1989 I was elected as vice president of the WFN. All this has left very pleasant memories of my 50 years of service with the WFN, which I can look back on in my retirement with contentment.

What I have written is entirely from my own memory of events, and there may be errors in small details, as I have never kept diaries of my life. Yet, constant recall over the years has left an indelible imprint somewhat mellowed by advanced age.

Acknowledgments
My thanks are due to the superintendent of Caxias in 1992 for permission to photograph and have photographs taken without reservation, a demonstration of heartwarming cordiality; to the Indian ambassador for arranging the revival visit for my wife and I; and to former WFN President Prof. Johan Aarli for stimulating me to write this account for the first time. I had earlier felt it was too personal to be of interest to anyone, but he believed that this would be worth a mention in his history of the WFN, which he is writing.

Finally, I thank my elder brother, Jimmy, without whose effort to get me released I would have remained longer in Caxias or suffered a worse fate; he also gave me the airport photographs.

**Figure 3.** I visited Portugal with my wife in 1992, where we visited Caxias and met the young superintendent of the prison (on right).

**Figure 4.** The photo on the left shows the outside of the dilapidated dungeon where I was confined, as seen in 1992. On the right, my wife and I stand outside a prison door in 1992.

**Figure 5.** This is a photograph of a coaster made by the prisoners, which the prison superintendent gave to my wife and I as a memento of our 1992 visit.

His experience with the government is another story.

I was told that we were not exchanged for Portuguese soldiers held prisoners in Goa. The three miners were released through the intervention of the Pope because they were Catholics and Salazar was also a devout one. I remember that they had asked for a Mass in the prison and were permitted to have it. As for me, I heard from a very reliable source that there was intervention on my behalf by some well-wishers of Indian origin from some of the African Portuguese colonies who had the confidence of Salazar. My exchange was for an iconic 400-year-old statue of Jesus Christ enshrined in a Goa church that Salazar wanted. I have never been able to fully confirm this information from any other source, but I am humbled, if it is true.

Somehow, I did not feel bitter or dejected and thanked God it was all over. And soon I was back to my old duties developing my department. Later in the year, I flew to Tokyo to participate in the WFN-organized first Asian Oceanian Congress of Neurology, Oct. 7-10, 1962. As we skirted China in the Air India plane, I wondered if fate would force me to land there, since by then India and China were having major border conflicts. Indeed, war broke out on Oct. 20, 1962!
Residual Symptoms Seen in Many Guillain-Barré Patients at 10 Years

BY JEFF EVANS
IMNG Medical News

Residual disability from Guillain-Barré syndrome that exists 1-2 years after onset may be lifelong, but most patients have minor symptoms and one-third of affected patients are normal 2 years after onset, according to a small, single-center study with 10 years of follow-up.

Most of the acute phase disability that was reported at 2 weeks after symptom onset had decreased significantly by 2 years among the cohort of 29 patients with Guillain-Barré syndrome (GBS). A small minority of patients also continued to improve slightly between 2 and 10 years. Although fully recovered patients described their health-related quality of life as very good, those with some residual symptoms reported fatigue and other subtle changes, such as slower walking speed.

“This prospective study shows that the residual disabilities at 1-2 years after GBS onset largely continue to persist at 10 years post-onset. This information might help clinicians in providing GBS patients with information about the long-term prognosis, and also in the planning of rehabilitation services,” Dr. Anette Forsberg and her colleagues at the Karolinska Institutet, Stockholm, wrote in their report (J. Neurol. Sci. 2012;317:74-9).

Other prospective clinical studies have reported moderate to severe disabilities in 10%-31% of patients at 1 year and in 16%-20% at 2 years. Cross-sectional studies with longer follow-up periods have found residual signs in 31%-48% of patients examined up to 6 years after onset. In the current study, 4 (14%) of the 29 patients had moderate to severe residual disabilities after 10 years, defined as a GBS disability score of at least 2 (on a scale of 0-7, where 0 means fully recovered).

Dr. Forsberg and her associates identified 42 patients with GBS at eight hospitals in Sweden who had previously taken part in a 2-year, prospective follow-up study (J. Neurol. Sci. 2004;227:131-8). Of the original 42 patients, 35 were alive 10 years later, but 4 declined to participate and 2 could not be found, leaving 29 in the study. At 10 years after GBS onset, these patients had a mean age of 59 years, ranging from 30 to 87 years.

Most improvement occurred in the first 6 months, and was mostly complete in 2 years. While initially none of the patients was normal, 10 (34%) of the 29 became normal after 2 years. This was the same at 10 years, so if a GBS patient did not achieve normality at 2 years, they weren’t likely to do so afterward. However, 4 patients continued to improve from 2 to 10 years.

Initially, 18 patients needed assisted ventilation or a wheelchair initially, but only 3 were using a wheelchair at 2 years and only 1 at 10 years.

Paresthesias, prominent in the feet and hands rather than in proximal areas of the extremities, declined over time in the patients from 93% at 2 weeks to 72% at 1 year, 59% at 2 years, and 38% at 10 years.

Facial palsy that was present in 13 (45%) at 2 weeks declined to 24% at 1 year, but 17% saw no further change at 2 and 10 years, “reflecting the poor prognosis of axonal damages to the facial nerve in GBS,” the investigators wrote.

At 10 years, health-related quality of life measured by the Sickness Impact Profile (SIP) were significantly worse in those who still had a GBS disability score greater than 1 in the categories of body care and movement, home management, ambulation, and recreation and pastimes. The item most often marked on the SIP at 10 years was “I have been slow in change,” which 2 at 10 years.

On another measurement of walking ability, the 12-item Walking Scale, 23 patients gave responses indicating limitations in walking (more slowly or less smoothly).

“These results reflect the fact that residual symptoms may be subtle, and therefore measures of physical capacity need to include aspects such as longer walking distances,” the investigators wrote.

The patients with a GBS disability score of at least 1 at 10 years had significantly higher mean scores on the Fatigue Severity Scale than did those who had fully recovered.

Cognitive Impairment Seen in Childhood CNS Vasculitis

BY BRUCE JANCIN
IMNG Medical News

BERLIN – Patients with childhood primary angiitis of the central nervous system are at elevated risk for poor cognitive outcome, and the risk is highest by far in the subgroup with small-vessel disease presenting with seizures.

In the years since use of immunosuppressive therapy has become common, mortality among affected children has lessened. “Most children survive. However, in day-to-day clinical practice, it’s our observation that what matters most to parents of these children is their longer term cognitive outcome. Parents ask us, ‘Will our child attend a regular school? Will our child achieve the same levels of academic performance and social and vocational accomplishments as their siblings?’” Dr. Peter Gowdie of the University of Toronto Hospital for Sick Children said at the annual European Congress of Rheumatology.

He and his colleagues sought answers to these questions in their single-center, retrospective, cohort study involving 63 patients with childhood primary angiitis of the CNS (cPACNS) without known premorbid cognitive deficits. Nineteen children had the small-vessel subtype, which is angiography negative and requires brain biopsy for diagnosis. Forty-four had large-vessel disease, which is identifiable on angiography and for which brain biopsy is therefore not indicated.

The median age at diagnosis was 8.1 years, with a median time to cognitive testing of 14.8 months.

Patients with large- and small-vessel cPACNS differed in several key ways in terms of clinical presentation (see chart), as previously noted in other studies.

Neurocognitive testing was carried out using the Wechsler Intelligence Scale for Children (WISC), a comprehensive battery of 10 subtests assessing a variety of domains. Scores of 85-115 on the full scale IQ portion of the WISC are considered within average range. The majority of children with small-vessel cPACNS – 53% to be exact – scored below 85, which indicates global cognitive impairment. This was twice the rate seen in children with large-vessel disease. The mean full scale IQ score in patients with small-vessel...
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Forging Relationships

**African Neurologists • from page 1**

EMG, evoked potentials, neurorehabilitation, grand rounds, journal club, case discussions, and outpatient clinic in our department and joined MRI interpretation sessions in the neuroradiology department. The language barrier was resolved with the help of a translator available sitting next to her.

Dr. Zebeenigu’s presentation on “Medicine and Neurology in Ethiopia” was very informative, interesting, and well attended by the staff members, residents, and medical students.

She was invited to Ankara Training and Research Hospital and Gazi University Neurology Departments where she was able to meet the neurology staff and observe their working environment. She met Dr. Wolfgang Grisold, cochair of the WFN Education Committee, and TNS council members during her visit to Istanbul where she had a brief tour in the historical city during the weekend. She was a highly motivated, knowledgeable, organized, and conscientious physician with excellent command of English. We were all very pleased to have her in our department.

I believe this program established by the WFN gave both sides excellent opportunities to have relations with mutual interests and share insights into their culture and health system. I’m sure Dr. Zebeenigu will be helpful to others when she is back.

The TNS supported this program with a strong belief in helping others, the benefit of cultural exchange, peace, and the standardization of neurological care in the whole world. I think the mission has been accomplished and we will be looking forward to having a continuous relationship with Dr. Zebeenigu, her colleagues from Ethiopia, and other African countries in the future as well.

**Dr. Tulay Kansu is professor of neurology at Hacettepe University School of Medicine. She also is the Turkish delegate to the WFN and a former president of the Turkish Neurological Society (2009-2011).**

**Dr. Philip B. Adebayo**

On March 18, 2012, Dr. Adebayo began a 1-month visit to our department of neurology at Cerrahpasa School of Medicine at Istanbul University.

Philip spent most of his time at our stroke unit, epilepsy division, EEG, and EMG labs, as well as the Doppler lab, sleep unit, and algology/ headge clinic, and he attended most of our noon conferences. These conferences varied according to the day of the week (on Mondays – case of the week and overview of the related neurologic condition; Tuesdays – residents’ presentation; Wednesdays – journal club, Thursdays – headache and cerebrovascular diseases rounds on alternative weeks; and Fridays – clinicopathological case discussions).

Dr. Adebayo also met with us at weekly neuroradiology interactive meetings on Wednesday mornings. There was either always one of our residents or a medical student who translated the ongoing activities and discussions and he was also informed by faculty members with whom he worked.

Philip gave a presentation soon before his departure at one of our noon meetings, which he titled “Nigeria, Neurology and My Cerrahpasa Experience.” We enjoyed his presentation and also learned a great deal about Nigeria and neurology in Nigeria and Africa. He then summarized his activities in the different sections of our department.

Philip is a wonderful person, very modest and hardworking. Everyone in our department liked him very much, from the faculty to our youngest residents, medical students and trainees, as well as secretaries, nurses, and technicians. I believe he will be one of the pioneers of modern neurology in his country and we will hear more of his achievements in the future. We will certainly keep in touch with him and his department.

Finally, the Turkish Neurological Society, through a private benefactor, would like to further support the African initiatives of the World Federation of Neurology by inviting one Kenyan colleague to visit the department of neurology at Cerrahpasa School of Medicine, Istanbul University.

**Dr. Akiel Siva is professor of neurology at Cerrahpasa Medical School, Istanbul University. He is the chairperson of the WFN Standards and Evaluations Committee and is a former president of the Turkish Neurological Society (2003-2009).**

**Continued from page 12**

cPACNS was 82, compared with 97 in those with large-vessel disease.

The specific cognitive domains where patients with small-vessel disease were disadvantaged were verbal comprehension, with a mean score of 91 compared with 101 in youngsters with large-vessel disease; processing speed, where the difference in mean scores was 83 versus 96; and working memory, on which patients with small-vessel cPACNS had an average score of 81 compared with 96 in those with large-vessel disease.

“Neurocognitive testing is helpful in determining the cognitive burden of cPACNS. Characterization of the cognitive deficits may be helpful in tailoring early rehabilitation interventions,” the rheumatologist said. Patients with large-vessel cPACNS and no seizures had an average Full Scale IQ score of 99. IQ scores were slightly but not significantly lower in those with large-vessel disease who presented with seizures as well as in those with small-vessel disease and no seizures. However, the mean full-scale IQ score was 79 in patients with small-vessel cPACNS who presented with seizures.

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**Key Differences in Clinical Phenotype at Presentation**

<table>
<thead>
<tr>
<th>Female gender</th>
<th>Seizures</th>
<th>Acute behavior</th>
<th>Hemiparesis change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>84%</td>
<td>79%</td>
<td>27%</td>
</tr>
<tr>
<td>Small-vessel cPACNS</td>
<td>30%</td>
<td>47%</td>
<td>14%</td>
</tr>
<tr>
<td>Large-vessel cPACNS</td>
<td>91%</td>
<td>37%</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Based on data for 63 children. All differences were statistically significant. Source: Dr. Gowdie

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**World Neurology** WWW.WFNNeurology.ORG • AUGUST 2012
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I arrived at the Cerrahpasa School of Medicine, Istanbul, on March 18, 2012, and quickly settled into my accommodations. My academic program had been sent earlier so I had ample time to revise it, and to plan how I would spend my time. I was warmly received by every member of the neurology department at Cerrahpasa, and I had no problem settling into the clinical and academic programs of the department. (I had to learn some Turkish in the process.)

I spent my Mondays with Dr. Baki Goksan at the stroke outpatient clinic. The clinic saw an average of 20-25 follow-up cases and 5-7 new cases. There also was an in-house carotid Doppler/transcranial Doppler system. The procedure was done every day in clinic. I learned the rudiments of carotid and transcranial Doppler ultrasonography. This clinic also provided the opportunity to interact with other members of the stroke unit, so it was easy to appreciate its stroke protocols. Another stroke outpatient clinic was run by Dr. Birsen Ince on Wednesdays. I was there on alternate Wednesdays.

My Tuesdays and Thursdays were spent in the Epilepsy Unit with Dr. Cigdem Ozkara and Dr. S. Naz Yeni. I joined EEG sessions on Monday (almost always after the stroke clinic since the EEG sessions ended later) as well as on Wednesdays. Participation in the EEG sessions has improved my skills in reading EEG, especially with video and sleep EEG, to which I was relatively new. I spent the alternate Wednesdays and Fridays in the electromyography (EMG) laboratory. I also spent 3 days in the sleep unit. The other periods were spent in the general neurology clinic and the movement disorder and headache clinics. I equally attended the Wednesday morning neuroradiology sessions and the daily noon meetings at one of which I gave a presentation titled, “Nigeria, Neurology and My Cerrahpasa Experience.”

The memory of this visit will linger with me for a long time. It was an exciting 4-week educational forum for me and a call to pursue excellence. I am beginning to see the impact of my visit already as I review our patients with neurologic disorders. I have adapted some of the protocols in Cerrahpasa to our local population in Ogbomoso (especially the headache and the movement disorder protocols). Although our infrastructure challenge may linger for a while and state-of-the-art equipment may still be far-fetching, I am of the opinion that well-trained doctors are not negotiable if we must map Africa’s way to prominence in neurology. I wish to thank the World Federation of Neurology, the Turkish Neurological Society, and the department of neurology at the Cerrahpasa Medical School for this opportunity. I also wish to thank Dr. Siva and Dr. Derya Uluduz for making my stay memorable.

In company of Dr. Aksel Siva (in dark jacket) after I gave my presentation “Nigeria, Neurology and My Cerrahpasa Experience.”

In the last week of my visit, I met with Dr. Tiday Kansu (left) and Dr. Wolfgang Grisold from the WFN in Istanbul.

In my second week, I gave a presentation on “Medicine and Neurology in Ethiopia” to neurology staff and residents.

In my last week, I accompanied Dr. Tiday Kansu to an executive committee meeting of the Turkish Neurological Society.

Dr. ADEBAYO is from the neurology unit in the department of medicine at Ladoke Akintola University and Teaching Hospital in Ogbomoso, Nigeria.

Dr. ZEVENIGUS is from the department of neurology in the school of medicine at Addis Ababa University, Ethiopia.

Hacettepe Visit
Building Relationships • from page 1

Hacettepe University, Ankara, is a well-known academic institution located in Turkey. It is home to various faculties including medicine and its affiliated schools, which provide medical education and training. The university is also known for its advanced medical facilities and research programs.

The neurology department at Hacettepe University is one of the leading departments in Turkey, offering a comprehensive range of services. It is staffed by highly qualified and experienced neurologists who are dedicated to providing the best care possible to their patients.

I was given the opportunity to present to the department staff at Hacettepe University as well as Ankara State Hospital in a joint session with Dr. Bernt Arda from Ankara University (who visited my department a year ago) on “medicine and neurology practice in Ethiopia,” which was highly appreciated and taken with enthusiasm.

My visit was spiced with off-work hour visits of wonderful and historical museums, city parks, open bazaars, and shops in Ankara, which still are fresh memories. I had the privilege of accompanying Dr. G. Kansu on her meeting trip to Istanbul on the last weekend of my stay, where I met with the executive committee of the Turkish Neurological Society. I had a historic tour of the extraordinary city of Istanbul as well. Although my journey was relatively short, I highly enjoyed being in Turkey and acquired as much new information as possible, which I have already put into practice.

I am hoping this is just the first of many more similar visits for other fellow colleagues in Africa and Ethiopia in particular.

I am hoping this is just the first of many more similar visits for other fellow colleagues in Africa and Ethiopia in particular.

My recommendations for future visits and visitors, who would make a similar visit, are:
- Provide focused training on one area of interest of the candidate.
- Plan for a longer period of visits—no less than 2-3 months.
- Provide an awarding certificate or letter to the candidate who completed visit.
- Build similar programs in other European countries to help African neurologists.
- Develop programs for European neurologists to visit African university hospitals.

I am grateful to Addis Ababa University, the head and staff of the department of neurology, and my colleagues at Vehuleshet Higher Clinic for making this visit a reality.

Dr. ZEVENIGUS is from the department of neurology in the school of medicine at Addis Ababa University, Ethiopia.
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