every other day. His condition has remained stable while tapering the dosage (5 mg each month) over the past few months. He has experienced no dysphagia at any time.

Subclinical limb neuropathy with areflexia and albuminocytological dissociation occurred within 2 months of our patient's initial complaint of diplopia. Symptoms of weakness and sensory loss, however, did not occur for another 4½ years. Thus, while the onset of subclinical limb neuropathy within 2 months after first experiencing diplopia is consistent with the course of Donaghy and Earl's patients, the prolonged delay in developing more overt sensorimotor symptoms is unique. Our patient is otherwise quite similar to those of Donaghy and Earl except for the absence of dysphagia and the apparently good response to immunosuppressive therapy thus far. In these respects, he more closely resembles the sixth case of Gibberd [2]. Our patient has, however, been followed for only 15 months since the onset of overt limb symptoms, and we recognize the possibility of future occurrence of such manifestations.

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The Initial Diagnosis of Multiple Sclerosis

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We were pleased to read the study by Gebarski and colleagues [2] about the great value of magnetic resonance imaging (MRI) in the initial diagnosis of multiple sclerosis (MS). However, we have concerns about the comparison of MRI with evoked potential (EP) tests. The data presented show that the EPs had an unusually low rate of abnormality in these 30 patients. Most studies of EPs in MS show much higher rates of abnormality, often with 90% of patients manifesting abnormalities in at least one EP modality even in the early stages of MS [1]. Another recent study by Tramo and colleagues [3] directly compared MRI and EPs in the diagnosis of MS at the initial presentation of the patient, and that study concluded that EPs are *more* sensitive than MRI. Perhaps the study by Gebarski and colleagues shows less sensitivity of EPs because of technical differences in the way that the EPs were carried out. No details of the EP procedures were given in the Subjects and Methods section. Details of EP testing would be very helpful, including the visual stimulus equipment, check size, contrast, field size, reversal rate, brainstem stimulus intensity and phase, somatosensory stimulus site, rate and intensity, and recording sites, as well as the various filter settings and normal limits used. It is also notable that only half of the patients had somatosensory EPs recorded, and presumably most of these did not have lower extremity stimulation done (which may be the EP most often positive in MS).

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Reply

Stephen S. Gebarski, MD, Trygve O. Gabrielsen, MD, Sid Gilman, MD, James E. Knake, MD, Joseph T. Latack, MD, and Alex Aisen, MD

We thank Drs Nuwer, Myers, and Ellison for their comments. We accepted for inclusion in our study all patients suspected of having multiple sclerosis following an initial evaluation by a neurologist on our faculty. The neurologists referring the patients to us ordered the ancillary laboratory tests, including the evoked potential studies. Many of the patients were referred to our neurologists from other medical centers where some laboratory tests, including evoked potential studies, were performed. Because of the costs involved, these were not consistently repeated in our institution. As Drs Nuwer, Myers, and Ellison correctly point out, not all patients received somatosensory evoked potential studies. Thus, the evoked potential studies in our report had a lower incidence of positive results than might be expected based on other findings reported in the literature. The study by Tramo and colleagues cited by Drs Nuwer, Myers, and Ellison included patients who had been ill for up to two years. These patients could not be considered, as a group, to reflect the findings in patients with the initial diagnosis of multiple sclerosis.

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