muscle vessels, we observed identical material localized within the laminar layer at the basement of the VSMC or scattered between the VSMC. In capillaries, despite the absence of elastica lamina, this granular material is also present, which suggests that this material does not originate from the elastica lamina as previously thought. The primary phenomenon might involve the VSMC, which are strikingly altered in skin and muscle vessels as well as in brain arteries in patients with CADASIL.

The pathophysiological significance and the specificity of these ultrastructural arterial lesions, particularly of the granular material, are unknown. The sensitivity and specificity of their presence in skin and muscle vessels should be evaluated in a case-control study. If the present results are confirmed, ultrastructural study of skin punch or muscle biopsy might be of crucial diagnostic value in patients with CADASIL, particularly in atypical or sporadic cases.

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Epileptic Seizures Heralding Intracerebral Hemorrhage

To the Editor:

The term "vascular precursor epilepsy" indicates seizures caused by cerebrovascular disease and occurring prior to a stroke, thus being a warning sign of a major cerebrovascular event. Although this definition includes no assumption about the type of stroke the seizures precede, it is generally assumed that seizures may herald ischemic but not hemorrhagic strokes. In fact, only very few and poorly documented cases of seizures occurring prior to a primary intracerebral hemorrhage (ICH) have been reported. Recent studies on epileptic seizures in the course of ICH10 give no account of heralding seizures, and in our series of 82 consecutive cases of ICH no patient had seizures preceding the stroke. However, we recently observed a patient whose new-onset seizures, having occurred prior to an ICH, suggested a relation between the two clinical entities.

A 55-year-old man began to experience sudden visual sensations of moving spots of light and more complex and formed visual hallucinations (geometric figures and written words) in his left visual field, where he also saw the objects distorted. The symptoms resolved completely within a few minutes, but the spells recurred several times daily; on the day after onset one of them rapidly progressed to a generalized tonic-clonic seizure. He was taken to an emergency unit, where an immediate computed tomographic (CT) scan revealed no brain lesions, and then to the neurology department of the University of Genova. On admission he reported mild hypertension, but no history of epilepsy, migraine, stroke, or head trauma. Physical and neurological examination findings were unremarkable except for a blood pressure of 170/110 mm Hg. Findings on repeat CT scan with contrast enhancement (Fig 1a), magnetic resonance imaging (MRI), and Tc-HMPAO (Tc-hexamethylene propyleneamine oxine)–single photon emission computed tomography, and Doppler sonography were normal. An electroencephalogram revealed slow and sharp waves over the right occipital region. The patient was diagnosed as having cryptographic late-onset partial seizures (visual) with secondary generalization, and antiepileptic treatment with carbamazepine and phenobarbital was started. Two months later, he came to the hospital again because of another spell of visual hallucination followed by sustained left hemianopsia; an MRI of the brain indicated a right occipital hemorrhage, which was confirmed by CT (Fig 1b). Transfemoral four-vessel angiography showed neither arteriovenous malformations nor signs of cerebral neoplasm, and the final diagnosis was lobar primary ICH. The patient improved, and serial CT scans showed a gradual resorption of hemorrhage without evidence of underlying lesion; he was put on antiepileptic and antihypertensive treatment and discharged from the hospital. During a 5-year follow-up his neurological status has been unchanged, indicating only mild left hemianopsia, and repeat neuroimaging revealed no further lesions of the brain. He is now seizure-free but still on antiepileptic treatment.

The patient had new-onset epileptic seizures prior to an ICH. An extensive neurological evaluation was done both at the onset of seizures and after the stroke. When epilepsy was the only symptom, the absence of any structural lesions of the brain warranted a diagnosis of cryptogenic late-onset seizures. After the hemorrhage, appropriate investigations and follow-up ruled out arteriovenous malformations and other underlying lesions, thus confirming the diagnosis of primary ICH.

Epilepsy and ICH were related in time (2 months) as well as in space (right occipital lobe); a coincidental association is therefore unlikely, despite the high frequency of both diseases in later life. The mechanisms by which seizures should herald an ICH are hard to conceive. In the case of cerebral infarction, ischemia may account for both seizures and stroke, and the high frequency of both diseases in later life. Cortical iron injection causes acute epileptiform activity in experimental models,11 and this finding has been claimed to account for posttraumatic and poststroke epilepsy. However, the relevance of this model to this case is questionable, because no hemorrhagic lesions (unless clinically silent) had ever occurred when seizures started.
This case raises the more general issue of the frequency, characteristics, and mechanisms of transient episodes preceding an hemorrhagic stroke. Indeed, transient neurological deficits, possibly resulting from a concurrent cerebral ischemia related to the underlying vascular disease, have been reported to herald an ICH in about 7% of patients. Taking for granted that a subclinical cerebral ischemia can trigger epileptic seizures, we suggest that the same determinants might be responsible for both paralytic and irritative manifestations, although seizures are less common than transient neurological deficits, and both are more likely to occur before a cerebral infarction than before a cerebral hemorrhage. As to the latter, the role of amyloid angiopathy should be emphasized, as well as that of atherosclerotic disease, because amyloid angiopathy may be responsible for both ischemic and hemorrhagic damage in the same patient.

In fact, our patient bears some similarities to another patient, described by Smith et al., in whom surgery revealed pathological features of amyloid angiopathy, and even more with patient 3 in the report by Greenberg et al. The latter patient, who was clinically diagnosed as having amyloid angiopathy, presented with transient visual spells regarded as epileptic seizures possibly due to a small hemorrhage that may have heralded a larger one; this hypothesis, however, was not verified because neuroimaging was available only after the stroke. In our patient there was no CT or MRI evidence of hemorrhage at the time of seizures, which indirectly favors the role of an ischemic mechanism rather than that of petechial hemorrhages. He may have amyloid angiopathy, although a 5-year follow-up indicated neither recurrences of ICH nor dementia. The existence of a cryptogenic hamartoma too indirectly favors the role of an ischemic mechanism rather than that of petechial hemorrhages. He may have amyloid angiopathy, and although a 5-year follow-up indicated neither recurrences of ICH nor dementia. The existence of a cryptogenic hamartoma too indirectly favors the role of an ischemic mechanism rather than that of petechial hemorrhages.

In conclusion, the occurrence of seizures prior to a stroke does not necessarily imply that a cerebral infarction has taken place. In fact, seizures heralding ICH, though uncommon, do occur. Although the mechanism is still obscure, the triggering role of a subclinical ischaemia related to the underlying vascular disease should be considered, at least in principle.

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