During orthostatic tests, it cannot be used because of circumstances. However, we would like to add that the autoregulatory response were taken at intervals of about 6 seconds are typically 5 seconds and may be as short as 3 seconds. The infrequent sampling of the first minutes of the autoregulatory response to a step decrease in MABP had returned to control values. However, we would like to add that we saw no discrepancy between these parameters in the period after this interval and could find no support for Dr Müller’s hypothesis that there may be a delayed dilatation of the MCA in the first minutes of the autoregulatory response to a step decrease in ABP.

We have been using a flow index method since 1986. Our experience with this method is that it is valid only under very specific circumstances. During orthostatic tests, it cannot be used because of the slight movements of probes and shifts in the position of the brain structures. Furthermore, the high-pass filtering of most instruments—including that used by Dr Müller—introduces errors because the flows below the filter levels are neglected in the result. In practice it is also difficult to achieve a sufficient signal-to-noise ratio for the method to be valid. Using our specially designed instrument to compare the Doppler flow index to the spectral outline during autoregulation, we never saw a power or flow index response like the one shown in Figs 1 and 2 in Dr Müller’s letter.
have been hypothesized, and these large multimers of von Willebrand molecules have been shown to clump platelets in vitro.

The neurological manifestations of TTP are diverse, but in most instances an acute confusional state, seizures, transient hemiparesis, and stupor predominate. The clinicopathologic correlation in patients with decreased levels of consciousness alone is problematic but may be related to widespread vascular involvement in the cortex. CT or MRI findings in TTP have been mostly linked to transient focal neurological deficits, but coma and fluctuating levels of consciousness have been correlated with multiple areas of decreased attenuation in white matter. Recently, a few reports of patients with TTP who undergo MRI have suggested that although recovery may be complete, small to minute cerebral infarcts can be demonstrated.

Our patient is of particular interest because his clinical course, documented by serial MRI scans, provides presumptive evidence that ischemic infarcts may go unnoticed. The diagnostic value of MRI in TTP has not been systematically evaluated, and in two recently investigated patients with decreased level of consciousness alone and relapsing TTP at our institution, MRI investigation was normal (E.F.M.W., unpublished data, 1994). The observation of unrelenting cerebral infarction may influence the decision of whether to use antiplatelet drugs or high doses of corticosteroids as adjuncts to plasma exchange.

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References

Segmental Narrowing of the Supraclinoid Carotid Artery in Young Patients With Ischemic Stroke

To the Editor:

An image of narrowing of the supraclinoid part of the internal carotid artery is occasionally seen on angiography in young patients with ischemic stroke. Because this angiographic feature is not specific, diagnosis usually remains uncertain except in fatal cases with pathological examination. We describe four young patients with cerebral infarction and stenosis of the supraclinoid carotid artery. The regressive nature of the angiographic abnormality made the diagnosis of dissection likely in three of the patients. In comparison with previously reported cases of spontaneous dissection of the intracranial carotid artery, these patients are noteworthy because of their favorable outcome.

Subjects were selected from a series of 141 patients aged 15 to 45 years, consecutively admitted to our department following ischemic stroke. Cerebral angiography, performed in 123 patients (87%), was obtained by transfemoral selective carotid opacification and repeated in all selected patients to assess the evolution of the arterial lesion. Clinical outcome was classified according to the Rankin scale.

Clinical and angiographic data are summarized in the Table. The mean age of the patients was 22.5 years. All patients presented with first-ever ischemic stroke. The cerebral infarction was limited to the territory of the anterior choroidal artery in three patients. There was no evidence of subarachnoid hemorrhage, drug addiction, or infection. Cerebrospinal fluid was analyzed in two cases and showed no abnormality. All patients were treated with anticoagulants alone or anticoagulants and then aspirin. Final disability was either absent or slight on the Rankin scale.
Silent brain infarct in thrombotic thrombocytopenic purpura.
E F Wijdicks

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