Gabapentin in carpal tunnel patients: A consideration

To the Editor: I read the publication by Erdemoglu et al., with great interest.[1] The authors reported the efficacy of gabapentin in patients with carpal tunnel syndrome and concluded that gabapentin is useful in patients who are reluctant to have surgery or have persistent symptoms following surgery. I agree that gabapentin can be an alternative approach for patients with carpal tunnel. Nevertheless, there are some points to be considered before generalization of this new approach. First, the long-term effect of gabapentin has not been studied yet. This has to be kept in mind and a close monitoring of long-term side effects is needed. Second, the data on comparative cost-effectiveness between gabapentin treatment and the classical approaches should be addressed.

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1. Erdemoglu AK. The efficacy and safety of gabapentin in carpal tunnel patients: Open label trial. Neurol India 2009;57:300-3.

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Correspondence

To the Editor: We read with interest the article “Finger drop sign in Guillain Barré syndrome.”[1] After reading the article we started examining our own patients with Gullian Barré Syndrome for this sign. Out of the four patients that we had in our ward at the time of reporting this, two had definite evidence of ‘finger drop sign’ with power of 3/5 and 4/5 in finger flexors and 0/5 and 1/5 in finger extensors respectively [Figure 1]. On electrophysiological examination, both these patients as well as the other two with no ‘finger drop sign’ had acute inflammatory demyelinating polyradiculoneuropathy (AIDP) with demonstrable conduction blocks, delayed distal latencies and slowed conduction velocities. However, both the patients with positive ‘finger drop sign’ had normal sensory conductions. Both of the patients were given intravenous immunoglobulins (IVIg) as they had definite worsening during observation in the hospital. Both the patients showed improvement at the time of discharge. The other two did not receive IVIg and improved spontaneously. One of the patients with ‘finger drop sign’ could be examined one month after discharge from the hospital; at this stage there was no evidence of this sign but relatively more weakness was present in finger extensors (power grade 3/5) compared to flexors (power grade 4/5).

Though our observation in no way denigrates the scientifically carried out study published in your journal, it certainly needs more evaluation as has been pointed out in the commentary by Pradhan[2] that followed the article, particularly in terms of the specificity and sensitivity of this sign.

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