Steele HE, Harris E, Barresi R, Marsh J, Beattie A, Bourke JP, Straub V, Chinnery PF.
Cardiac involvement in hereditary myopathy with early respiratory failure: A cohort study.
Neurology 2016, 87(10), 1031-1035.

Copyright:
This is an open access article distributed under the terms of the Creative Commons Attribution License 4.0 (CC BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

DOI link to article:
http://dx.doi.org/10.1212/WNL.0000000000003064

Date deposited:
23/11/2016
Cardiac involvement in hereditary myopathy with early respiratory failure
A cohort study

ABSTRACT

Objective: To assess whether hereditary myopathy with early respiratory failure (HMERF) due to the c.951434T>C; (p.Cys31712Arg) TTN missense mutation also includes a cardiac phenotype.

Method: Clinical cohort study of our HMERF cohort using ECG, 2D echocardiogram, and cross-sectional cardiac imaging with MRI or CT.

Results: We studied 22 participants with the c.951434T>C; (p.Cys31712Arg) TTN missense mutation. Three were deceased. Cardiac conduction abnormalities were identified in 7/22 (32%): sustained atrioventricular tachycardia (n = 2), atrial fibrillation (n = 2), nonsustained atrial tachycardia (n = 1), premature supraventricular complexes (n = 1), and unexplained sinus bradycardia (n = 1). In addition, 4/22 (18%) had imaging evidence of otherwise unexplained cardiomyopathy. These findings are supported by histopathologic correlation suggestive of myocardial cytoskeletal remodeling.

Conclusions: Coexisting cardiac and skeletal muscle involvement is not uncommon in patients with HMERF arising due to the c.951434T>C; (p.Cys31712Arg) TTN mutation. All patients with pathogenic or putative pathogenic TTN mutations should be offered periodic cardiac surveillance.

Neurology® 2016;87:1031–1035

GLOSSARY

HMERF = hereditary myopathy with early respiratory failure; LV = left ventricular; MFM = myofibrillar myopathy; NIV = noninvasive ventilation; RV = right ventricular.

Hereditary myopathy with early respiratory failure (HMERF) is an autosomal dominant disorder arising due to missense mutations in the fibronectin III domain of the TTN gene, most commonly c.951434T>C; (p.Cys31712Arg). HMERF is characterized by adult onset of distal or proximal muscle weakness in association with early respiratory muscle weakness, which may be the presenting feature and require noninvasive ventilation. Muscle biopsy findings are largely nonspecific, although myofibrillar myopathy and cytoplasmic bodies are described.

Other skeletal myopathies caused by missense mutations in titin include tibial muscular dystrophy due to heterozygous mutations in the C-terminus and limb-girdle muscular dystrophy type 2J arising from recessive mutations at the same locus. Cardiac complications in these phenotypes have not been reported previously. Conversely, heterozygous truncating TTN mutations are a recognized cause of dilated and restrictive cardiomyopathies without apparent skeletal muscle involvement. However, the rare coexistence of skeletal and cardiac muscle disease in recessive truncating titin mutations raises the possibility that cardiac involvement may occur in other titinopathies. This has implications for the surveillance of those at risk. To address this, we carried out the first systematic cardiac study in HMERF using multimodal structural and functional cardiac imaging.

From the John Walton Muscular Dystrophy Research Centre (H.E.S., E.H., R.B., J.M., V.S.), Newcastle University; Department of Cardiology (A.B., J.P.B.), Freeman Hospital, NUTH NHS Foundation Trust; Medical Research Council Mitochondrial Biology Unit (P.F.C.); and Department of Clinical Neurosciences (P.F.C.), School of Clinical Medicine, University of Cambridge, UK.

Go to Neurology.org for full disclosures. Funding information and disclosures deemed relevant by the authors, if any, are provided at the end of the article. The Article Processing Charge was paid by the Wellcome Trust.

This is an open access article distributed under the terms of the Creative Commons Attribution License 4.0 (CC BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

© 2016 American Academy of Neurology 1031
<table>
<thead>
<tr>
<th>Patient and family ID</th>
<th>Sex</th>
<th>Age at onset, y</th>
<th>DisD, y</th>
<th>Skeletal muscle pattern</th>
<th>Function</th>
<th>PFTs (% predicted)</th>
<th>Cardiac Hx, lx, and Mx</th>
<th>12-Lead ECG</th>
<th>Echo summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>30</td>
<td>14</td>
<td>Distal LL</td>
<td>Unaided</td>
<td>FEV₁ 72, FVC 71</td>
<td>N</td>
<td>No medication</td>
<td>Low-amplitude p waves</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>37</td>
<td>6</td>
<td>Distal &gt; proximal LL &gt; UL</td>
<td>AFO</td>
<td>52, 68</td>
<td>N</td>
<td>Ramipril for high BP</td>
<td>Normal</td>
</tr>
<tr>
<td>3</td>
<td>B</td>
<td>33</td>
<td>13</td>
<td>Distal and proximal LL and distal UL</td>
<td>Unaided</td>
<td>83, 85</td>
<td>Y</td>
<td>No medication</td>
<td>Normal</td>
</tr>
<tr>
<td>4</td>
<td>B</td>
<td>40</td>
<td>10</td>
<td>Distal and proximal UL and LL and axial</td>
<td>Unaided</td>
<td>uk, 53</td>
<td>N</td>
<td>Propranolol intermittently; 24-hour ECG = 11 beats AT</td>
<td>Tachycardic with premature atrial ectopics</td>
</tr>
<tr>
<td>5</td>
<td>B</td>
<td>45</td>
<td>2</td>
<td>Mild distal UL and LL</td>
<td>Unaided</td>
<td>67, 70</td>
<td>N</td>
<td>Palpitations; no meds; 24-hour ECG = normal</td>
<td>Normal</td>
</tr>
<tr>
<td>6</td>
<td>B</td>
<td>60</td>
<td>14</td>
<td>Mild distal LL weakness</td>
<td>Unaided</td>
<td>67, 62</td>
<td>N</td>
<td>No medication</td>
<td>Bradycardic: 55 bpm</td>
</tr>
<tr>
<td>7</td>
<td>B</td>
<td>16</td>
<td>32</td>
<td>Distal and proximal LL; distal UL</td>
<td>Stick</td>
<td>uk, 73</td>
<td>N</td>
<td>No medication</td>
<td>Notched p waves</td>
</tr>
<tr>
<td>8</td>
<td>B</td>
<td>29</td>
<td>14</td>
<td>Distal and proximal LL</td>
<td>Unaided</td>
<td>70, 64</td>
<td>Y</td>
<td>AVNRT: ablation; no meds</td>
<td>Normal</td>
</tr>
<tr>
<td>9</td>
<td>B</td>
<td>35</td>
<td>30</td>
<td>Distal and proximal UL and LL</td>
<td>WC</td>
<td>33, 32</td>
<td>Y</td>
<td>Lisinopril for high BP</td>
<td>Premature SV complexes</td>
</tr>
<tr>
<td>10</td>
<td>B</td>
<td>44</td>
<td>15</td>
<td>Distal and proximal UL and LL</td>
<td>WC</td>
<td>67, 63</td>
<td>Y</td>
<td>Palpitations; atorvastatin</td>
<td>Normal</td>
</tr>
<tr>
<td>11</td>
<td>B</td>
<td>20</td>
<td>34</td>
<td>Distal and proximal UL and LL</td>
<td>Crutch and AFO</td>
<td>57, 55</td>
<td>N</td>
<td>2012: Perindopril 4 mg, bisoprolol 2.5 mg; 2014: Perindopril 4 mg, bisoprolol 5 mg</td>
<td>Low-amplitude p waves, normal PR, flattened T waves (evolving over 2 years)</td>
</tr>
<tr>
<td>12</td>
<td>B</td>
<td>46</td>
<td>10</td>
<td>Distal and proximal LL; distal UL</td>
<td>WC</td>
<td>73, 71</td>
<td>N</td>
<td>No medication</td>
<td>Premature atrial complexes</td>
</tr>
<tr>
<td>13</td>
<td>C</td>
<td>35</td>
<td>6</td>
<td>Distal and proximal LL; proximal UL</td>
<td>WC</td>
<td>uk, 77</td>
<td>N</td>
<td>No medication</td>
<td>Low-amplitude notched p waves, nonspecific flattened T waves (evolving over 3 years)</td>
</tr>
<tr>
<td>14</td>
<td>C</td>
<td>NA</td>
<td>NA</td>
<td>Nil</td>
<td>Unaided</td>
<td>uk, 77</td>
<td>N</td>
<td>No medication</td>
<td>Normal</td>
</tr>
<tr>
<td>15</td>
<td>D</td>
<td>28</td>
<td>5</td>
<td>Distal and proximal UL and LL</td>
<td>AFO</td>
<td>uk, 70</td>
<td>N</td>
<td>No medication</td>
<td>Normal</td>
</tr>
<tr>
<td>16</td>
<td>E</td>
<td>30</td>
<td>27</td>
<td>Distal LL and UL</td>
<td>uk</td>
<td>uk, 68</td>
<td>N</td>
<td>No medication</td>
<td>uk</td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>39</td>
<td>8</td>
<td>Distal LL and UL</td>
<td>uk</td>
<td>uk, uk, uk, uk</td>
<td>No medication</td>
<td>No medication</td>
<td>Normal</td>
</tr>
<tr>
<td>18</td>
<td>G</td>
<td>27</td>
<td>15</td>
<td>Distal and proximal LL &gt; distal LL</td>
<td>AFO</td>
<td>55, 56</td>
<td>N</td>
<td>No medication</td>
<td>uk</td>
</tr>
<tr>
<td>19</td>
<td>H</td>
<td>30</td>
<td>33</td>
<td>Distal LL and UL</td>
<td>uk</td>
<td>uk, 56</td>
<td>Y</td>
<td>SVT, bisoprolol</td>
<td>uk</td>
</tr>
<tr>
<td>20*</td>
<td>I</td>
<td>45</td>
<td>4</td>
<td>Proximal and distal LL; proximal UL</td>
<td>Stick</td>
<td>67, 71</td>
<td>N</td>
<td>No cardiac hx or medication</td>
<td>uk</td>
</tr>
<tr>
<td>21*</td>
<td>J</td>
<td>uk</td>
<td>uk</td>
<td>Proximal and distal LL; mild proximal UL</td>
<td>uk</td>
<td>uk, uk, uk</td>
<td>Y</td>
<td>PPM, AVR, uk medication</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>22*</td>
<td>C</td>
<td>44</td>
<td>30</td>
<td>Distal &gt; proximal LL &gt; UL</td>
<td>WC</td>
<td>33, 27</td>
<td>Y</td>
<td>2010: Bisoprolol 2.5 mg, furosemide 20-40 mg, 24-hour ECG: AF with variable rate</td>
<td>Atrial fibrillation</td>
</tr>
</tbody>
</table>

Abbreviations: AF = atrial fibrillation; AFO = ankle foot orthosis; AT = atrial tachycardia; AVNRT = atrioventricular nodal reentrant tachycardia; AVR = aortic valve replacement; BP = blood pressure; bpm = beats per minute; CM = cardiomyopathy; DD = diastolic dysfunction; DisD = disease duration; EF = ejection fraction; FEV₁ = forced expiratory volume in 1 second; FVC = forced vital capacity; Hx = history; imp = impaired; lx = investigations; LL = lower limb; LV = left ventricular; Mx = management; NA = not applicable; NFA = normal for age; NIV = noninvasive ventilation; PFTs = pulmonary function tests; PPM = permanent pacemaker; PR = PR interval; RV = right ventricular; SVT = supraventricular tachycardia; UL = upper limb; uk = unknown; WC = wheelchair; * = deceased patients.
METHODS All participants known to the John Walton Muscular Dystrophy Research Centre, Newcastle upon Tyne, United Kingdom, with the c.951434T>C; (p.Cys31712Arg) TTN nonsense mutation had a 12-lead ECG and echocardiogram requested as part of routine clinical care. All available cardiac test results were reviewed. Thereafter, all participants residing within the North East of England were invited to attend for a cardiac MRI, irrespective of cardiac symptomatology or initial findings. Where participants were unable to tolerate MRI, cardiac CT scan was offered.

All cardiac MRIs were performed on a 1.5T Siemens MRI scanner using a standardized cardiomyopathy protocol, with black blood anatomical, multiplanar short tau inversion recovery, multiplanar cines—including short axis stack for ventricular function, multiplanar cines, and delayed enhancement sequences obtained with gadoterate meglumine (Dotarem, Guerbet, Villepinte, France). All cardiac CT imaging was performed on a Siemens dual source CT scanner retrospectively gated at low dose for functional information only with a Flash mode delayed enhancement series 7 minutes following iohexol (Omnipaque; GE Healthcare, Cleveland, OH) administration.

Histopathologic correlation. Based on previous reports of desmin as a marker of cardiac dysfunction, we undertook analysis of frozen myocardial samples collected postmortem from 3 patients with HMERF.

Immunohistochemistry. Immunolabeling for β-spectrin (clone RBC2/3D5), desmin (DAKO M0760; Glostrup, Denmark), myotilin (NCL-Myotilin; Leica Biosystems, Newcastle, UK), VCP (BD Biosciences, East Rutherford, NJ), ubiquitin (NCL-UBIQm; Leica Biosystems), and p62 (Abcam ab56416; Cambridge, UK) was undertaken.

Western blot. Myocardial samples from patients and age-matched controls with no reported cardiac pathology were homogenized and run on sodium dodecyl sulfate polyacrylamide gel electrophoresis (4%–12% gradient). Immunoblotting was performed using the antibody against desmin. Immunoblots were visualized with SuperSignal West Pico Chemiluminescent Substrate detection using AlphaInnotech FluorChem Q platform and AlphaView software v3.0. All tests were performed in duplicate.

RESULTS We identified 22 participants with the c.951434T>C; (p.Cys31712Arg) TTN mutation. Three were deceased. Eighteen attended for echocardiogram, of whom 6 subsequently had cardiac MRI and 4 cardiac CT imaging. Two individuals failed to attend planned MRI scans. Cross-sectional imaging was not requested in 7 patients due to geographic dispersion. Clinical features are outlined in table 1.

We identified conduction abnormalities in 32% (7/22) of patients. These included sustained atrioventricular tachycardia (8B and 19H), nonsustained atrial tachycardia (4B; figure, A), premature supraventricular complexes (9B), unexplained sinus bradycardia (6B), and atrial fibrillation (21J and 22C). Patients 8B and 19H were treated with bisoprolol and 8B underwent catheter ablation. Patients 5B and 10B had a history of...
palpitations without specific diagnosis being reached despite investigation.

Asymptomatic global left ventricular systolic dysfunction was evident in 4/22 (18%) patients (1A, 11B, 13C, and 22*) on echocardiogram (tables 1 and 2). Although none had chamber dilation, the findings were compatible with nonischemic cardiomyopathy. Two were known to have reduced left ventricular (LV) ejection fraction at study onset (11B and 13C), and one was identified with mild right ventricular (RV) systolic dysfunction in the course of the study (1A). We identified subepicardial fibrosis in 11B on late gadolinium-enhanced MRI (figure, B). None had other lifestyle, history, or medical risk factors to explain their cardiac features.

Four individuals had evidence of possible or definite LV diastolic dysfunction by E-E’ measures on echocardiography. Patient 9B was on maintenance lisinopril for hypertension, but none of the others (3B, 4B, 6B) had any history of cardiac disease, cardioactive medication use, or prior cardiologic assessment. Patients 6B and 9B underwent cross-sectional cardiac imaging with CT and mild diastolic impairment was confirmed in 6B (tables 1 and 2).

**Response to treatment.** Participant 11B demonstrated sustained improvement in cardiac function in the 2012–2015 period following initiation of perindopril and bisoprolol therapy. Left ventricular function improved in patient 22* after commencing β-blocker therapy (table 1).

**Relationship to disease onset.** The age range of individuals developing cardiomyopathy overlapped with those without (40–65 and 33–65 years, respectively) and with disease duration (6–34 and 2–33 years, respectively). Cardiomyopathy emerged 4–30 years after first skeletal muscle symptoms (table 1).

**Relationship to respiratory disease.** We assessed the relationship of confirmed ventricular systolic dysfunction at any time with respiratory disease and noninvasive ventilation (NIV) use. No relationship was identified between ventricular systolic impairment and respiratory disease (reduction in pulmonary function tests of 25% or more from predicted) or use of NIV (p = 0.2722 and p = 0.2778, respectively; Fisher exact test).

**Histopathologic correlation.** **Immunohistochemistry.** Myocardial tissue preservation was satisfactory in patient 20*, degraded in patient 21* (figure, C), and unsuitable for further analysis in patient 22*. Immunolabeling for myofibrillar proteins was unremarkable and did not demonstrate abnormal protein accumulation (not shown).

**Immunoblot.** Desmin expression was upregulated (approximately 2.5-fold) in patient 20* compared to controls, suggesting myocardial cytoskeletal remodeling.* Patient 21* showed reduced desmin expression consistent with extensive postmortem delay (figure, D).

**DISCUSSION** Our findings show that cardiac involvement is not uncommon in patients with the c.951434T>C (p.Cys31712Arg) TTN missense mutation. Conduction abnormalities occurred in a third of patients, with atrial fibrillation and sustained paroxysmal atrioventricular tachycardia most frequently identified (2/22; 9% each). The prevalence of the latter arrhythmia

### Table 2 Cardiac MRI and CT features

<table>
<thead>
<tr>
<th>Patient and family</th>
<th>ID</th>
<th>Ix</th>
<th>RV: Ejection fraction, %</th>
<th>LV: Ejection fraction, %</th>
<th>Fibrosis?</th>
<th>Corrected end LV diastolic volume, mL/m²</th>
<th>Corrected end RV diastolic volume, mL/m²</th>
<th>Overall impression</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>MRI</td>
<td>44</td>
<td>60</td>
<td>N</td>
<td>51 (56-96)</td>
<td>63 (48-112)</td>
<td>(1) Subtle dysynchronous ventricular contractions; (2) mild RV impairment</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>MRI</td>
<td>64</td>
<td>70</td>
<td>N</td>
<td>56 (57-105)</td>
<td>59 (61-121)</td>
<td>Normal</td>
</tr>
<tr>
<td>5</td>
<td>B</td>
<td>CT</td>
<td>57</td>
<td>60</td>
<td>N</td>
<td>65 (57-105)</td>
<td>77 (61-121)</td>
<td>Normal</td>
</tr>
<tr>
<td>6</td>
<td>B</td>
<td>CT</td>
<td>50</td>
<td>74</td>
<td>N</td>
<td>65 (57-105)</td>
<td>109 (61-121)</td>
<td>Possible early cardiomyopathy; LVEF and LV volume in URN; no medication</td>
</tr>
<tr>
<td>7</td>
<td>B</td>
<td>MRI</td>
<td>45</td>
<td>53</td>
<td>N</td>
<td>65 (57-105)</td>
<td>77 (61-121)</td>
<td>Normal (no cardiac medication)</td>
</tr>
<tr>
<td>8</td>
<td>B</td>
<td>MRI</td>
<td>56</td>
<td>57</td>
<td>N</td>
<td>56 (58-96)</td>
<td>69 (48-112)</td>
<td>Normal</td>
</tr>
<tr>
<td>9</td>
<td>B</td>
<td>CT</td>
<td>63</td>
<td>72</td>
<td>N</td>
<td>66 (57-105)</td>
<td>92 (55-105)</td>
<td>(1) Subepicardial fibrosis; (2) RV impairment without dilation of RV/PA</td>
</tr>
<tr>
<td>11</td>
<td>B</td>
<td>MRI</td>
<td>41</td>
<td>60</td>
<td>Y</td>
<td>67 (57-105)</td>
<td>64 (61-121)</td>
<td>Mild nondilated, nonischemic cardiomyopathy</td>
</tr>
<tr>
<td>13</td>
<td>C</td>
<td>MRI</td>
<td>31</td>
<td>38</td>
<td>N</td>
<td>49 (47-92)</td>
<td>64 (61-121)</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**Abbreviations:** Ix = investigations; LV = left ventricle; LVEF = left ventricular ejection fraction; PA = pulmonary artery; RV = right ventricle; URN = upper range of normal.
is significantly higher than seen in the general population (9% vs 0.2%; p = 0.0026; Fisher exact test). 2

Additionally, cardiomyopathy was identified in 18% (4/22). Importantly, this was responsive to standard cardioactive therapies. Interestingly, the presence of either LV or RV dysfunction was independent of respiratory failure, suggesting that the mechanism is not secondary to nocturnal hypoventilation, restrictive pulmonary physiology, or cor pulmonale. The etiology of the diastolic dysfunction observed is uncertain given the absence of LV hypertrophy or significant fibrosis. Diastolic dysfunction is a recognized feature of cardiovascular aging and consequently, is the most likely explanation for our findings. However, a disease-specific association cannot be excluded.

As a recently recognized cause of myofibrillar myopathy (MFM), the TTN mutation causing HMERF is now included in genetic testing panels for MFM. Cardiac involvement in other myofibrillar myopathies, also encompassing arhythmia and cardiomyopathy, is well-recognized, with an estimated prevalence of 30%. 10 Our findings are in keeping with this.

The main limitation of our study is its pragmatic nature as it was conducted in the context of routine clinical health care. Consequently, the echocardiograms were performed and reported by several—albeit experienced—echo-technicians and the CT scans were reported retrospectively. While MRI remains the gold standard for assessment of ventricular function, use of CT in this population, with neuromuscular respiratory failure and NIV, enabled more patients to undergo cross-sectional cardiac imaging. Although the 2 modalities are not directly comparable, where imaging is undertaken longitudinally using the same method, an assessment of change can be made.

As the full spectrum of cardiac and skeletal muscle phenotypes associated with TTN mutations remains unknown, patients with pathogenic or putative pathogenic TTN mutations should be offered periodic cardiac surveillance. However, based on the findings we present here, some of the observed abnormalities may be due to normal aging, and not TTN cardiomyopathy per se.

ACKNOWLEDGMENT

The authors thank the patients, cardiac technicians, and radiographers for their assistance in screening patients. Direct sequencing of the common HMERF missense mutation c.951434T>C; (p.Cys31712Arg) was performed by the Northern Genetics Service. Mutations are reported using the reference sequence NM_001267550.1.

STUDY FUNDING

P.F.C. is a Wellcome Trust Senior Fellow in Clinical Science (101876/Z/13/Z) and a UK NIHR Senior Investigator who receives support from the Medical Research Council Mitochondrial Biology Unit (MC_UP_1501/2), the Wellcome Trust Centre for Mitochondrial Research (096919/Z/11/Z), the Medical Research Council (UK) Centre for Translational Muscle Disease research (G0601943), EU FP7 TIRCON, and the National Institute for Health Research (NIHR) Biomedical Research Centre based at Cambridge University Hospitals NHS Foundation Trust and the University of Cambridge. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health.

DISCLOSURE

The authors report no disclosures relevant to the manuscript. Go to Neurology.org for full disclosures.

Received January 25, 2016. Accepted in final form May 26, 2016.

REFERENCES

Cardiac involvement in hereditary myopathy with early respiratory failure: A cohort study
Hannah E. Steele, Elizabeth Harris, Rita Barresi, et al.
Neurology 2016;87;1031-1035 Published Online before print August 10, 2016
DOI 10.1212/WNL.0000000000003064

This information is current as of August 10, 2016

Updated Information & Services
including high resolution figures, can be found at:
http://www.neurology.org/content/87/10/1031.full.html

References
This article cites 10 articles, 3 of which you can access for free at:
http://www.neurology.org/content/87/10/1031.full.html##ref-list-1

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
All Genetics
http://www.neurology.org/cgi/collection/all_genetics
All Neuromuscular Disease
http://www.neurology.org/cgi/collection/all_neuromuscular_disease
CT
http://www.neurology.org/cgi/collection/ct
MRI
http://www.neurology.org/cgi/collection/mri
Muscle disease
http://www.neurology.org/cgi/collection/muscle_disease

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
http://www.neurology.org/misc/about.xhtml#permissions

Reprints
Information about ordering reprints can be found online:
http://www.neurology.org/misc/addir.xhtml#reprintsus