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## In reply—Continued Caution Recommended in Use of Intravenous Iron Preparations

We thank Dr Cachat and colleagues for their interest in our article and for the

valuable information they are reporting. We tried to conduct an unbiased systematic review, but we are aware of the shortcomings of using published results of randomized, controlled trials (RCTs) to report severe adverse events: severe events are too rare to be captured by RCTs (this is why we included all trials on intravenous iron), recording of adverse events might be less rigorous and more biased than that of the primary outcome in such studies, the patients included in RCTs might not be representative of the patients given the drug in clinical practice, and for some medications, the time frame for identifying the adverse events might be the wrong one.

Postmarketing surveillance adds valuable information, but we should remember that it lacks comparison, and some of the patients given iron have severe underlying disorders. Further, the quality of the reported data might be problematic.

As clinicians, we need to weigh all available data when offering intravenous iron to our patients, and the postmarketing surveillance should be part of these data.

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## Familial Transient Global Amnesia

**To the Editor:** We acclaim the excellent, comprehensive review of transient global amnesia (TGA) by Arena and Rabinstein<sup>1</sup> in the February 2015 issue of *Mayo Clinic Proceedings*. Considering the unknown pathophysiology of TGA, we note the authors make minimal mention of the possible contribution of genetics (on page 267). We request

that the authors comment further on this possibility.

We report herein our experience with 2 sisters who presented with classic episodes of TGA. The first sister was a 57-year-old woman who suddenly became amnesic after having intercourse with her husband. Her husband noticed that she could not remember their sexual act right after they finished, and she kept repeating the same questions several times over. Approximately 1 year later, her 71-year-old sister presented. That morning, she said she had a mild headache and was “not feeling well.” On the drive home from church, she kept asking the same questions repeatedly and could not recall having been at church just a few minutes before.

Neither sister had other neurologic or systemic symptoms. Their presentation examination results were normal except for poor short-term memory. Other than having impaired memory for the events associated with their presentations, they were back to normal the following day. The first sister had experienced a transient ischemic attack 7 years before. Neither had a history of stroke, head trauma, seizures, migraines, or episodes of memory loss.

The second sister's work-up included brain magnetic resonance imaging, which revealed an isolated punctate region of hyperintense signal on diffusion-weighted imaging in the left hippocampus but no signal changes on the T2-weighted or fluid-attenuated inversion recovery sequences. The magnetic resonance imaging study was not repeated.

We are not the only clinicians who have encountered familial cases of TGA. Among the most prominent published series is that of Corston and Godwin-Austen,<sup>2</sup> who described 4 brothers who each had had multiple attacks. Segers-van Rijn and de Bruijn<sup>3</sup> described a family in which 4 of 8 siblings had TGA experiences, one of whom had 2 episodes. Dupuis et al<sup>4</sup> described twin sisters who experienced multiple episodes of TGA associated

with migraines. Finally, Munro and Loizou<sup>5</sup> described a family of 2 siblings and their father who had experienced TGA episodes, 2 of whom had multiple episodes.

We acknowledge that these rare familial clusters of TGA cases may just be coincidental. Yet in the absence of a confirmed etiology for TGA, they do provide evidence that TGA may have a genetic component. We suggest that clinicians obtain careful family histories of their patients with TGA and consider publishing reports of any who may have a positive family history. Whether they lead to predisposing factors, a diagnostic marker, or the etiology, such reports will advance the understanding of TGA.

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## In reply—Familial Transient Global Amnesia

We thank Dr Dandapat and colleagues for their complimentary comments on our review and for sharing their clinical experience with us. As they correctly

point out, there have been a few reports of familial clusters of transient global amnesia (TGA) cases.<sup>1-6</sup> Given the relative infrequency of TGA, it is reasonable to consider that these familial clusters may not be just coincidental. Details provided on these familial cases have been sometimes incomplete, but we found that migraine was a comorbidity in at least one of the family members with TGA in 4 of the 6 familial cases reported in the literature.<sup>2,3,5,6</sup> Thus, a common genetic predisposition to migraine and TGA<sup>7,8</sup> could potentially explain familial aggregation. Further research will be necessary to clarify this possibility.

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## Dissatisfaction as a Unifying Force for Social Action

**To the Editor:** In their article published in the February 2015 issue of *Mayo Clinic Proceedings*, O'Donnell et al<sup>1</sup> are right to mention dissatisfaction with

the practice of medicine as a major factor that generates physicians' lackluster interest in addressing health policy issues. However, there is another factor that must be mentioned, the fact that most medical students do not learn the importance of defending medicine's ideals in medical school or in residency. They are too busy learning the basics of being doctors, and once they are in practice, the importance of participating in medical affairs seems like a waste of time compared with the demands of practice, personal life, and continuing medical education.

The point is that although physicians who are dissatisfied with practice may be "disinclined" to address the great issues that affect their professionalism, dissatisfaction itself is a poor excuse. It is a rationalization that condones and worsens doctors' reluctance and hesitation. Clearly, it is a cop-out.

Dissatisfaction should serve as a unifying force that brings doctors together, a catalyst that leads them to activism. Clearly, not all doctors have the time or are motivated to take a serious interest in health care policy, but obviously more are needed. It is up to our medical schools to teach students the importance of protecting physicians' professionalism. If it doesn't start in medical school, there is little hope of it starting at all.

**Edward Volpintesta, MD**

Bethel, CT

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## In reply—Dissatisfaction as a Unifying Force for Social Action

Dr Volpintesta raises a number of interesting points, particularly with respect to how one's early medical education might set his or her trajectory for future