

least yearly. Males, 19 to 30 years, in higher socio-economic classes, formed the majority continuing to drive without adequate seizure control. Based on the recommendations of the Ad Hoc Committee of Epilepsy International, the authors proposed that: (1) a driving license may be granted only to an epileptic who has been seizure-free for at least 1 year; (2) temporary permits may be granted in exceptional circumstances to certain individuals on the advice of a certified neurologist having special interest and competence in epilepsy. (Gastaut H, Zifkin BG. The risk of automobile accidents with seizures occurring while driving: relation to seizure type. Neurology 1987;37:1613-1616).

COMMENT: In the State of Illinois, patients with epilepsy may obtain a license to drive at the discretion and on the advice of the neurologist in charge of treatment. Temporary permits are not issued. Although questioned concerning the duration of care, the occurrence of attacks in the past 6 months, of a type without warning and with loss of consciousness, and the patient's compliance in taking medication, a neurologist's certificate to the effect that the patient is medically fit to operate a motor vehicle is usually sufficient, irrespective of the frequency or pattern of seizures. A more restrictive policy toward epileptics and driving, including a one year period of control, was counterproductive, forcing patients to deny the recurrence of seizures and thereby preventing the prescription of optimal therapy. The present study appears to support the discretionary policy based on individualized applications for driving licenses of epileptics, but the monitoring of young male drivers with complex partial seizures should be close and frequent and should include serum drug levels and when appropriate, repeated EEG's to check drug compliance and seizure susceptibility.

INFECTIOUS DISEASES

HERPES SIMPLEX ENCEPHALITIS

The successful outcome of a case of herpes simplex encephalitis (HSE) in a pregnant woman at 29 weeks gestation is reported from the Depts of Neurology and Gynecology and Obstetrics, Royal Perth Hospital and the State Health Lab Services, Perth, Western Australia. The diagnosis was suspected from the clinical presentation with fever, headache, stupor, generalized convulsion, a focal EEG, and a hypodense area in the right temporal lobe on CT. It was confirmed retrospectively from evidence of specific antibody production in the CSF. Acyclovir 800 mg/d IV every 8 hours and in a reducing regime was continued for 22 days. She recovered after 2 months and delivered a normal unaffected baby. Mother has led a normal life except for right sided focal motor and grand mal seizures controlled with anticonvulsants for 3½ years and secondary to post-encephalitic temporal lobe atrophy. The child, aged 3½ years, is well. Infection with HSV in this patient was not disseminated and did not cross the placenta. Acyclovir was non-toxic to mother and fetus when used in the 3rd trimester of pregnancy. (Hankey, GJ, Bucens MR, Chambers JSW. Herpes simplex encephalitis in third trimester of pregnancy: successful outcome for mother and child. Neurology 1987;37:1534-1537).

COMMENT: This case of HSE is the sixth to be reported in pregnancy

and the second to survive. Only one previous fetus has survived a pregnancy complicated by HSE and the mother, treated with idoxuridine, died 5 days postpartum. Acyclovir reduces mortality of neonatal HSE and is well tolerated but morbidity in surviving infants is high especially if treatment is delayed. Early diagnosis is facilitated by MRI. (Scroth G et al. Neurology 1987;37:179). For a review of the natural history of HSV infection of mother and newborn and therapy of neonatal HSV infection, see Whitley RJ et al. and Infectious Disease Collaboration Antiviral Study Group. Pediatrics 1980;66:489-501.

HERPES ZOSTER OPHTHALMICUS

A 17-month-old boy with HZO and delayed contralateral hemiparesis following intrauterine varicella exposure is reported from the Dept of Neurology, Univ Texas Med Sch, Houston, TX. He presented with ataxia and a progressive right-sided weakness. His mother had chicken-pox at 8 months of gestation but he appeared normal at birth. A vesicular rash developed 4 weeks before examination in the distribution of the ophthalmic and mandibular divisions of the left trigeminal nerve. CSF showed mononuclear pleocytosis, CT demonstrated multiple areas of hypodensity in the left basal ganglia, and angiography revealed occlusion of the left lenticulostriate arteries. Treatment with Acyclovir for 10 days was followed by recovery except for minimal right hemiparesis. (Leis AA, Butler IJ. Infantile herpes zoster ophthalmicus and acute hemiparesis following intrauterine chickenpox. Neurology 1987;37:1537-1538). Passive immunization of susceptible women exposed to varicella is recommended to reduce the risks of maternal and fetal varicella. The determination of varicella zoster virus membrane antigen or equivalent anti-varicella antibody status in pregnant women exposed to varicella is a rapid, satisfactory method for determining who should receive varicella immunoglobulin passive immunization (McGregor JA et al. Am J Obstet Gynecol 1987;157:281).

COMMENT: The authors cited only one similar previous case in a child, a 7-year-old boy. Delayed focal cerebral angiitis and infarction may occur after an interval of days to months between HZO and neurologic complications in adults. Passive immunization of exposed susceptible women reduces risks of maternal and fetal varicella. (McGregor JA et al. Am J Obstet Gynec 1987;157:281).

LANGUAGE AND BEHAVIOR

CROSSED APHASIA

A case of crossed aphasia with persistent language disturbances in a right-handed boy aged 5 yr 9 mos is reported from the Centre Hospitalier Universitaire Vaudois, Lausanne, France. An acute left hemiplegia resulted from occlusion of the internal carotid siphon of undetermined cause and demonstrated by arteriography. The boy was mute, his auditory comprehension impaired, and tongue and facial movements apraxic. His first intelligible words (maman and non) were pronounced at 2 months after the onset. The language remained agrammatic and the vocabulary and comprehension poor but the tongue apraxia resolved. Twelve years later, language disturbances were still present although his IQ on the WAIS was 100 full scale, 86 verbal (information 6, comprehension 6, digit memory 5,