values. The mean CSF levels of substance P in patients with mental retardation, epilepsy, and Guillain-Barre disease were not different from controls without neurologic disease. (Matsuishi T, Nagamitsu S, Yamashita Y et al. Decreased cerebrospinal fluid levels of substance P in patients with Rett syndrome. Ann Neurol Dec 1997;42:978-981). (Respond: Dr Matsuishi, Department of Pediatrics and Child Health, Kurume UIniversity School of Medicine, 67 Asahi-machi, Kurume City, Japan 830).

COMMENT. CSF concentrations of substance P have been shown to reflect brain and spinal cord concentrations. The authors suggest that decreased CSF levels of substance P in patients with RS, if confirmed in other studies, may be useful as a biological marker for the disease.

SPEECH AND LANGUAGE DISORDERS

ACQUIRED CHILDHOOD DYSARTHRIA CLASSIFICATION

Published reports of acquired childhood dysarthria since 1980 were reviewed at University Hospital, Rotterdam; and the Department of Medical Psychology, Ziekenhuis Walcheren, Vlissingen, The Netherlands, and cases were classified on the basis of neuroradiological location of lesion and associated motor disorders. The majority of cases (20) were examples of mutism and subsequent dysarthria (MSD) following resection of cerebellar tumor. Slow articulation, monotony, and hoarse soft voice were the most frequent manifestation of dysarthria, and all patients had severe limb and trunk ataxia. Recovery or improvements in speech and motor disability were dissociated, dysarthria resolving first and almost completely while ataxia often persisted. Cerebellar MSD in children is different from the adult form of ataxic dysarthria, which is characterized by excess and equal stress resulting in scanning speech. Scanning speech was rarely observed in children. In 5 children with basal ganglia lesions and extrapyramidal movement disorders, dysarthria was characterized by hypophonia, stuttering, and difficulty in controlling rate of speech, similar to the hypokinetic dysarthria in adults. Acquired dysarthria in childhood requires a separate classification from that of adults. (van Mourik M, Catsman-Berrevoets CE, Paquier PF, Yousef-Bak E, van Dongen HR. Acquired childhood dysarthria: Review of its clinical presentation. Pediatr Neurol Nov 1997;17:299-307). (Respond: Dr van Mourik, Department of Medical Psychology/Ziekenhuis Walcheren, Postbus 3200, 4380 DD Vlissingen, The Netherlands).

COMMENT. Acquired childhood dysarthria is classified as 1) ataxic type, usually following mutism as a complication of cerebellar tumor resection; and 2) hypokinetic type associated with basal ganglia lesions and extrapyramidal movement disorders.

The syndrome of cerebellar mutism and subsequent dysarthria is covered in Progress in Pediatric Neurology III, PNB Publishers, 1997;pp306-307. A report from University Hospital, Rotterdam cites 36 cases in the literature, including 5 of 15 children operated for cerebellar tumor, mainly medulloblastoma, at that hospital. The mutism was correlated with adherence of the tumor to the floor of the fourth ventricle. The dysarthria that followed lasted for 1 to 5 weeks.

SEIZURE DISORDERS

PREVALENCE OF LENNOX-GASTAUT SYNDROME IN ATLANTA

The prevalence and epidemiology of Lennox-Gastaut syndrome (LGS)

among metropolitan Atlanta children were studied at the University of Kentucky, Lexington, KY, and Centers for Disease Control and Prevention, USPHS, Atlanta, GA, using data from the Metropolitan Atlanta Developmental Disabilities Study. The lifetime prevalence of LGS at age 10 years was 0.26/1000, accounting for 4% of all childhood epilepsy. Mental retardation (IQ <70) was present in 91%, and a history of infantile spasms in 39%. Of children with profound mental retardation (IQ <20) in Atlanta, 17% had LGS. LGS causes a disproportionate degree of morbidity and health care costs among children with epilepsy because of the multiple complications, including cerebral palsy, mental retardation, visual and hearing impairments, status epilepticus, and frequent falls with injury. (Trevathan E, Murphy CC, Yeargin-Allsopp. Prevalence and descriptive epidemiology of Lennox-Gastaut syndrome among Atlanta children. Epilepsia Dec 1997;38:1283-1288). (Reprints: Dr E Trevathan, Epilepsy Center, Department of Neurology, University of Kentusky, Kentucky Clinic, Room L-445, Lexington, KY 40536).

COMMENT. The prevalence of Lennox-Gastaut syndrome in a population based study among Atlanta children is 0.26/1000, and 4% of all childhood epilepsy. The relatively high morbidity and increased health care costs of treating childhood LGS should prompt multicenter collaborative research projects to identify etiological risk factors, preventive measures, and more effective therapy.

See Progress in Pediatric Neurology III, 1997;pp82-83, for previous reports of the prevalence of epilepsy: 6/1000 among 10-year-old children in Atlanta (Murphy CC et al, 1995), and 9.8/1000 among children <15 years in Rochester, MN (Hauser WA, 1994).

PREVALENCE OF EPILEPTIC SYNDROMES IN FINLAND

The prevalence of epilepsy and types of seizures and epileptic syndromes in children in the district of the Tampere University Hospital (population 175,000) and 34 surrounding rural counties was determined by a retrospective review of medical records and EEG recordings, using the latest ILAE International Classifications. Prevalence of epilepsy in 1992 was 3.94 per 1000, and 96% of seizures and 90% of epileptic syndromes could be classified. Generalized seizures and syndromes were more prevalent in young children 0-6 years of age, and partial/localization-related seizures in older children 6-15 years. Intractable epilepsies in 17% of all cases correlated with symptomatic etiology and early onset of seizures. Lennox-Gastaut accounted for 2% of epilepsies, and 10% were unclassified. (Eriksson KJ, Koivikko MJ. Prevalence, cl;assification, and severity of epilepsy and epileptic syndromes in children. Epilepsia Dec 1997;38:1275-1282). (Reprints: Dr KJ Erilsson, Tampere University Hospital, Department of Pediatrics, PO Box 2000, FIN-335621 Tampere, Finland).

COMMENT. Intractable seizures account for 17% of all epilepsies in a defined population of children in Finland. The prevalence of childhood epilepsy in the Finland population (3.94/1000) is much lower than that in Atlanta (6/1000) and Rochester, MN, USA (9.8/1000).

PHENOBARBITAL FOR CHILDHOOD EPILEPSY IN RURAL INDIA

The acceptability of phenobarbital as a first-line drug for childhood epilepsy in rural settings in developing countries was studied using a randomized comparison of phenobarbital and phenytoin as monotherapy in West Bengal, India, and results were analyzed at the Institute of Child Health, University College London, UK, the MRC Biostatistics Unit, Cambridge, and Child-in-Need Institute, Daulutpur, West Bengal, India. Phenobarbital (1.5 mg/kg daily for 2