in 16% of the VPA and 21% of CBZ-treated patients, point to an increased risk of rickets and bone fractures in some children. The importance of monitoring calcium intake and bone metabolism of women with epilepsy is stressed in the following articles.

MANAGEMENT OF EPILEPSY ISSUES IN WOMEN

Management issues for women with epilepsy (WWE) are reviewed by a team of investigators in conjunction with the AAN Quality Standards Subcommittee. A literature search reveals the need for outcome studies as a base for practice recommendations on contraception, folate supplements, vitamin K use in pregnancy, breast-feeding, metabolic bone disease, catamenial epilepsy, and reproductive endocrine disorders. (Zahn CA, Morrell MJ, Collins SD, Labiner DM, Yerby MS. Management issues for women with epilepsy. A review of the literature. Neurology Oct 1998;51:949-956). (Reprints: Dr Catherine Zahn, The Toronto Hospital, Western Division, 8 Edith Cavell-034, 399 Bathurst St, Toronto, Ontario M5T 2S8, Canada).

Options recommended by the AAN for WWE that might apply in pediatric neurology practice include use of ethinyl estradiol or mestranol (at least 50 mcg) for women choosing hormonal contraception during treatment with AEDs, and prepregnancy counseling regarding need for folic acid supplements, risks of teratogenic effects of AEDs, and possible withdrawal or change to a safer AED regimen at least 6 months before conception. (American Academy of Neurology. Practice parameter. Management issues for women with epilepsy (summary statement). Neurology Oct 1998;51:944-948). (Reprints: AAN, 1080 Montreal Ave, St Paul, MN 55116).

COMMENT. For pediatric neurologists who treat adolescents and young adults with epilepsy, these counseling suggestions for WWE are a useful resource.

FOSPHENYTOIN IN INFANTS AND CHILDREN

The pharmacokinetics, safety, and tolerability of fosphenytoin in children from 1 day to 16 years old and the data available from 78 patients in two multicenter studies are reviewed from the Medical College of Virginia Commonwealth University, Richmond, VA. The conversion half-life of fosphenytoin to phenytoin following intravenous administration in 62 patients was 8.3 min (range, 2.5-18.5 min), with no relation to age. Plasma total phenytoin concentrations of 10-40 mcg/ml were obtained by 15 min. In 16 patients receiving intramuscular fosphenytoin, 5.5 mL, plasma total phenytoin concentrations of 10 mcg/mL were reached within 20 min. The equivalent plasma free phenytoin concentration was 1 mcg/mL. IV infusion rates were 0.5-3 mg PE/kg/min. IM loading doses ranged from 12-20 mg PE/kg, administered in one to three sites. Mild bruising, tenderness, swelling, and/or erythema occurred at infusion or injection sites in 3 (6%) of 52 patients with adequate records. Common systemic reactions included emesis, nystagmus, ataxia, and pruritus. (Morton LD. Clinical experience with fosphenytoin in children. J Child Neurol Oct 1998;13(Suppl 1):S19-S22). (Respond: Dr Lawrence D Morton, Department of Pediatric Neurology, Virginia Commonwealth University, Medical College of Virginia Campus, 307 College Street, 7th floor, Richmond, VA 23219).

COMMENT. The advantages of fosphenytoin over phenytoin for parenteral administration include a pH closer to neutral, solubility and compatibility with intravenous fluids, and less discomfort and adverse reaction. The higher cost of fosphenytoin cf phenytoin is offset by the lower rates of complications and