authors disagreed with the conclusion of Gilbert and Buncher (Neurology 2000;54:635-641) that the EEG should not be routinely performed after a first seizure because it does not alter treatment. In contrast, the committee concludes that the EEG helps in determination of seizure type, the diagnosis of epilepsy syndromes, and risk of recurrence; it provides information on long-term prognosis; it influences the decision to perform neuroimaging studies; and it may affect further management. The optimal timing of the EEG is not clear. It is most likely to show abnormalities when obtained within 24 hours of the seizure, although postictal slowing may be transient and must be interpreted with caution.

BENIGN CHILDHOOD OCCIPITAL EPILEPSY

The clinical and EEG features of the syndrome of benign childhood occipital epilepsy (Panayiotopoulos syndrome [PS]) were studied in 66 patients seen between 1990 and 1997 at the Hospital Nacional de Pediatria "Juan P Garrahan," Buenos Aires, Argentina. In the same time period, 145 children were diagnosed with the syndrome of benign childhood epilepsy with centrotemporal spikes (BECTS). Inclusion criteria for PS included ictal vomiting (100%), deviation of eyes and head (98%), clonic partial seizures (33%), impaired consciousness, and secondary generalization to convulsions (39%). Prolonged seizures and partial status epilepticus occurred in one third. Seizures were nocturnal in all patients and also diurnal in one third. Ictal visual symptoms occurred in 9%. Five had concurrent rolandic epilepsy (BECTS) and another 5 developed rolandic seizures after remission of PS. Prognosis was excellent. A single seizure occurred in 30%, 49% had infrequent sporadic recurrences, and 18% had seizures every 1 to 5 months. The EEG showed occipital spikes in all 66 children; spikes were bilateral or unilateral, activated by sleep, and paroxysms were blocked by eye-opening. One-third also had centrotemporal and frontal spikes. None had generalized spike-wave discharges. Following treatment with antiepileptic drugs, principally carbamazepine, 90% had no further seizures. Seizures remitted within 1 to 8 years (mean 5.5 years) from onset despite persistent EEG abnormalities in 75%. (Caraballo R, Cersosimo R, Medina C, Fejerman N. Panayiotopoulos-type benign childhood occipital epilepsy. Neurology October (2 of 2) 2000;55:1096-1100). (Reprints: Dr Robert Caraballo MD, Combate de los Pozos 1881 (1245), Buenos Aires, Argentina).

COMMENT: The authors conclude that Panayiotopoulos syndrome (PS), or P-type childhood epilepsy with occipital paroxysms (CEOP), is a relatively common, homogeneous, and benign syndrome that deserves wider recognition. Unusual seizure manifestations such as vomiting and a first prolonged seizure may mimic encephalitis or intoxication. Most reports have emphasized the excellent prognosis, with remission in 1 to 2 years, and one-third of cases with only one seizure.

An editorial by Berg AT and Panayiotopoulos CP (Neurology Oct (2 of 2) 2000;55:1073-1074) outlines the typical presenting symptoms of the syndrome, and proposes a continuum of interrelated, benign, childhood, partial epilepsy syndromes. PS prevalence is about half that of BECTS. They emphasize the frequent initial presentation with status epilepticus and vomiting, symptoms that may suggest a more serious underlying process, leading to misdiagnosis. They advocate inclusion of the PS syndrome in the ILAE classification of epileptic syndromes.

Interictal clonic/atonic symptoms occurring in BECTS may be caused by overmedication and may warrant AED withdrawal or substitution (de Saint-Martin A et al. Neurology Oct (2 of 2) 2000;55:1241-1242).