

deficits. (Stan SK, Baumann, RJ. Outcome of neonatal strokes. AJDC Oct 1988;142:1086-1088).

COMMENT. The authors conclude that infants with a unilateral arterial stroke generally have a favorable prognosis initially but require long-term follow up for possible recurrence of seizures and development of learning disabilities. Comparing these results with a previous report of neonatal stroke (See Ped Neur Briefs Aug 1988;2:63-64), the increased prevalence of left middle cerebral artery infarction and the frequent complication of neonatal seizures are in agreement, but the recovery of neurologic function within 1 year is in contrast to a persistent hemiparesis in 66% of patients examined at 1-4 years of age.

INFECTIOUS DISEASE

BACTEREMIA AND FEBRILE SEIZURES

The frequency of occult bacteremia among children treated as outpatients for simple febrile seizures has been investigated in the Dept of Pediatrics, Univ of Maryland School of Medicine and St. Agnes Hospital, Baltimore, MD. Patients seen with fever but without a history of febrile seizures had blood cultures performed more frequently than those with a history of seizures. Of 115 patients with febrile seizures, 93 had blood cultures of which 5 (5.4%) were positive, all for *Streptococcus pneumoniae*. Follow-up blood cultures on return to the ER were negative. Three of the 5 had been treated with amoxicillin suspension for otitis media and 2 had not received antibiotics. There was no significant difference in the occurrence of positive blood cultures in those with and without a history of febrile convulsions. The leukocyte count was the most valuable predictor of bacteremia. A temperature less than 39°C and leukocyte count less than 15×10^9 /L were predictive of a negative blood culture. Of those with a positive culture, the mean leukocyte count was 20.9×10^9 /L and the mean temperature was 40.2°C. Patients admitted to the hospital because of complications (e.g. meningitis, status epilepticus, facial cellulitis, and reactions to DPT vaccine) were excluded from the analysis. The authors recommend that the indications for blood culture are the same in patients with fever, with or without seizures. (Chamberlain JM, Gorman RL. Occult bacteremia in children with simple febrile seizures. AJDC Oct 1988;142:1073- 1076).

COMMENT. It is interesting that the American Academy of Pediatrics Consensus statement from 1980 regarding the workup for febrile seizures did not include mention of blood culture. The authors of the paper reviewed here point out that patients with fever complicated by seizure

are at the same risk for occult bacteremia as patients with fever alone, and should receive the same attention with regard to blood cultures. My colleague, Dr. Subhash Chaudhary, Head of the Division of Pediatric Infectious Disease at SIU School of Medicine, commented on the indications for blood culture in young children with fever but with no recognized focus of infection: "a child who looks sick and/or has a WBC of 20,000 or more should receive a blood culture and initial treatment with an antibiotic effective against pneumococcus and H influenza type b pending the isolation of an organism."

NONTRAUMATIC LUMBAR PUNCTURE

A technique and formula for avoiding the traumatic spinal tap is reported from the Medical College of Wisconsin, Milwaukee, WI. To increase the accuracy and to minimize the frequency of traumatic puncture, the authors conducted a 12-month prospective analysis of 158 children of various ages in whom this diagnostic procedure was performed during the evaluation of an acute illness. The right lateral decubitus position was used and the needle was inserted perpendicularly in the L-3 to L-4 vertebral interspace. After CSF was collected, the needle was marked at the skin line and the length inserted was measured. The patient's age, weight, and height were used to calculate the body-surface area in square meters. The body-surface area showed the highest correlation with the depth of lumbar puncture. Linear regression for surface area provided a simple formula to estimate the depth of puncture to within 5 mm in young children of all ages:

$$\text{Depth} = 0.77 \text{ cm} + 2.56 (\text{m}^2)$$

(Bonadio WA et al. Estimating lumbar-puncture depth in children. N Engl J Med Oct 6 1988;319:952-953).

COMMENT. Insertion of the needle too deeply with puncture of venous plexuses in the anterior wall of the vertebral wall is the most common error. The avoidance of traumatic lumbar puncture by the use of this simple calculation and formula should facilitate the diagnosis of meningitis and reduce the risk of iatrogenic meningitis resulting from blood contamination of a previously sterile CSF in the patient with bacteremia. The authors are to be congratulated on their attempt to introduce some mathematical accuracy into a commonly "hit or miss" procedure.

INVOLUNTARY MOVEMENTS

SYDENHAM'S CHOREA THERAPY

Five patients with chorea successfully treated with carbamazepine at plasma levels of 6.5 - 8.8 mcg/ml are reported from the Dept of Pediatrics, Child Neurology and EEG Service, Hospital Infantil Vall d'Hebron, Autonomous University,