

patients with migraine lasting longer than 72 hours. (Friedman BW, Greenwald P, Bania TC, et al. Randomized trial of IV dexamethasone for acute migraine in the emergency department. **Neurology** Nov 27, 2007;69(22):2038-2044). (Reprints: E-mail: bfriedm@montefiore.org).

COMMENT. The authors comment that the benefit in persistent migraine relief rates found for dexamethasone in this study should be interpreted with caution because this was a subgroup analysis. Becker WJ, Kryscio RJ, in an editorial (**Neurology** 2007;69:2034-2035), note that others have reported benefits of dexamethasone, especially with larger doses and with headache endpoints beyond 24 hours post-treatment.

SEIZURE DISORDERS

LONG-TERM SOCIAL OUTCOMES IN CHILDHOOD EPILEPSY

Population-based longitudinal and cross-sectional studies of social outcomes of children with epilepsy in different countries are reviewed by researchers at Dalhousie University, Halifax, Nova Scotia, Canada. The Isle of Wight UK study (Rutter et al, 1970) found psychiatric problems in 25% of children with epilepsy compared to 7-9% of normal controls. A Finnish series of children with epilepsy followed to 22 years of age had severe learning disorders in 20% compared to 2% of controls (Kokkonen et al, 1997). At longer follow-up, patients were more likely on disability pension (12% vs 2% controls), twice as likely to be unemployed, and more often unmarried, living alone or with parents (69% vs 40% controls). Cognitive or neurologic disability accounted for the poor social outcome, and seizure control and socioeconomic status were unrelated to the outcome. In Japan (Wakamoto et al, 2000), unlike Finland, normally intelligent young adults with epilepsy had favorable long-term educational and employment outcomes, but the mentally retarded did poorly. In Turku, Finland (Sillanpaa, 1990; Jalava et al, 1997), adults with childhood epilepsy had reduced levels of education, employability, social economic status, and successful marriage ($p=0.0001$), and 15% were dependent on other caretakers. Those on AEDs were less satisfied with their quality of life than those off medication.

In the Canadian Nova Scotia, population-based epilepsy cohort study (Camfield et al, 1993, 2007; Wirrell et al, 1997), poor social outcome was more common in patients with a learning disorder. Young adults with childhood absence epilepsy had less education, lower working status and higher rates of behavioral and psychiatric difficulty than a chronic disease control group with juvenile rheumatoid arthritis. Children with secondary generalized epilepsy were often mentally handicapped and/or highly dependent with refractory seizures. (Camfield CS, Camfield PR. Long-term social outcomes for children with epilepsy. **Epilepsia** December 2007;48(Suppl.9):3-5). (Respond: Carol S Camfield MD, FRCP(C), IWK Health Centre, PO Box 9700, Halifax, Nova Scotia, Canada B3K 6R8. E-mail: Camfield@dal.ca).

COMMENT. Learning disorder and mental handicap are the most significant risk factors for poor social outcome in adults with a history of childhood epilepsy. The effect of epilepsy on social outcome is greater than that of other childhood chronic disease.

Cognitive difficulties in children with idiopathic epilepsy are demonstrated in measures of verbal and visuospatial memory at delays of 30 minutes and 1 week. (Davidson M et al. Memory consolidation and accelerated forgetting in children with idiopathic generalized epilepsy. *Epilepsy & Behav* Nov 2007;11(3):394-400). Poor initial learning efficiency led to an accelerated rate of forgetting auditory-verbal information, with poor recall/recognition scores at 1 week, compared to controls. Impaired initial learning did not affect retrieval at the 30-minute delay.

MANAGEMENT OF PEDIATRIC NONEPILEPTIC SEIZURES

The neurologist's and child psychiatrist's perspectives of the diagnosis and treatment of pediatric nonepileptic seizures (NES) were discussed at a multidisciplinary workshop sponsored by the National Institutes of Neurological Disorders and Stroke and of Mental Health, and the American Epilepsy Society, May 2005. The term 'psychogenic' was avoided, since this might be considered prematurely dismissive of possible biological disorders. Childhood paroxysmal "spells," from a neurologist's perspective, have a broad differential diagnosis, and require video EEG, MRI, cardiology evaluation, and various laboratory tests to exclude an organic cause. Events that occur in stressful social situations are suggestive of NES, whereas those occurring during sleep are suggestive of sleep-related events or epileptic seizures. The diagnosis is determined by exclusion and negative video-telemetry and by evidence for an underlying conversion disorder. Alexithymia (difficulty talking about negative feelings), and presence of conflict (eg. school difficulties, social, and family problems) should be elicited by interviewing the child and parents, sometimes separately. Parents often minimize the child's psychological problems and are convinced of an "organic" cause for the symptoms. Clinician acumen and sensitivity are essential to elicit stressors and coping style of the child and to penetrate a denial barrier of a parent. A clinician's explanation and understanding of the impact of stress on the patient's symptoms is a helpful technique in gaining the family confidence. Initial feedback is presented first to the parent and then the child. The word 'seizure' is avoided and is replaced by 'episode' and 'event'. Multidisciplinary management is emphasized, including the child's school staff. (Plioplys S, Asato MR, Bursch B, et al. Multidisciplinary management of pediatric nonepileptic seizures. *J Am Acad Child Adolesc Psychiatry* Nov 2007;46(11): 1491-1495). (Respond: Dr Sigita Plioplys, Department of Child and Adolescent Psychiatry, Children's Memorial Hospital, 2300 Children's Plaza, Box #10, Chicago, IL 60614).

COMMENT. The management of non-epileptic paroxysmal "spells" (NES) in a child with a conversion disorder is difficult, and requires the skill of an experienced and understanding clinician. To inform the parent and child that the symptoms are 'psychogenic' will lose their confidence and trust and will probably exacerbate the disorder. The acceptance of the symptoms as real, however unconvincing, and the exclusion of an organic etiology is the first responsibility of the neurologist. NES are often associated with epileptic seizures, compounding the difficulties in differentiation. A behavioral approach to reduce the reinforcement the patient receives during a NES or event at home or school, if introduced promptly, may prevent escalation of symptoms and the need for psychiatric admission. As advised by the panel, a supportive, calm, and reassuring stance is required in dealing with the patient and parent during an episode or event.