Center, Israel. Age range was 3-11 months (mean 5.6 mos). CSF pleocytosis occurred in 42 (27.3%), including 1 case of bacterial meningitis (0.6%). Other diagnoses were aseptic meningitis (26.7%), URI infection (18.3%), viral disease NOS (15.6%), roseola infantum (8.5%), and acute otitis media (6.5%). Appearance on admission was good to excellent in 113 (73.6%) infants, none of whom had bacterial meningitis. All infants who appeared well on admission had normal clinical, laboratory and imaging studies and non-bacterial disease. Observation and withholding of lumbar puncture are considered appropriate in febrile infants with bulging fontanelle who appear clinically well. (Shacham S, Kozer E, Bahat H, Mordish Y, Goldman M. Bulging fontanelle in febrile infants: is lumbar puncture mandatory? **Arch Dis Child** 2009;94:690-692). (Respond: Dr S Shacham. E-mail: shirashacham@gmail.com).

COMMENT. Bulging fontanelle and fever alone are not always sufficient indication for lumbar puncture. LP is mandatory if these signs are complicated by febrile seizure, toxemia, rash, nuchal rigidity or other signs of meningitis.

## SEVERE, INFANTILE-ONSET SEIZURE PATTERN IN STURGE-WEBER SYNDROME

Researchers at the Hunter Nelson Sturge-Weber Center, Kennedy Krieger Institute, Baltimore, reviewed the records of 100 consecutive children and adults with confirmed Sturge-Weber syndrome (SWS) to determine the nature and prognosis of associated seizures. In 77 patients seen over a 5-year period, median age of seizure onset was 6 months, with 43 (56%) presenting <1 year of age. The port-wine birthmark was unilateral (left face) in 28 (36%), bilateral in 19 (25%), and right in 18 (23%). All patients had at least one complex partial seizure, 11 (14%) also had generalized seizures, including infantile spasms, atonic, and absence, as previously reported (Fukuyama et al, 1979). Thirty-five (45%) patients had clusters of seizures (multiple, recurring over a 24-h period or prolonged >30 min). Young age at seizure onset (<6 months) was associated with increased hemiparesis.

In 30 (39%) patients, a characteristic seizure pattern consisted of sporadic clustering of severe, infantile-onset seizures followed by prolonged seizure-free periods. The cluster pattern was not associated with a worse prognosis. Also, disability was not increased in patients with bihemispheric involvement. (Kossof EH, Ferenc L, Comi AM. An infantile-onset, severe, yet sporadic seizure pattern is common in Sturge-Weber syndrome. **Epilepsia** Sept 2009;50:2154-2157). (Respond: Eric H Kossoff MD, Suite 2158-200 North Wolfe Street, The Johns Hopkins Hospital, Baltimore, MD 21287, (E-mail: ekossoff@jhmi.edu).

COMMENT. The authors comment that this frequently occurring cluster pattern of seizures may cause confusion regarding optimal anticonvulsant therapy and timing of resective surgery. Since the seizure pattern is not accompanied by worsening of cognitive or motor function, chronic anticonvulsant therapy with potential cognitive side effects may be replaced by more frequent use of rescue benzodiazepine treatment at time of clusters, and surgery may be deferred.

**GABA effects on excitability of SWS cortex.** In contrast to previous data showing excitatory and proconvulsive actions of GABA in epilepsies, GABA had inhibitory and anticonvulsive effects on in vitro SWS pediatric cortex. (Tyzio R, Khlilov I, Represa A, et al. **Ann Neurol** Aug 2009;66:209-218). E-mail: khazipov@inmed.univ-mrs.fr.