

Also, the possibility of defining clinically important subgroups of febrile seizures might be facilitated by the use of the EEG. It is emphasized that the EEG recordings should include natural sleep and wakefulness, drowsiness, at least stages I and II of nonrapid eye movement sleep, and arousal. Failure to standardize the procedure makes comparisons between different studies very difficult. (Stores G. When does an EEG contribute to the management of febrile seizures? Arch Dis Child April 1991; 66:554-557).

COMMENT. The author correctly emphasizes the need for standardized EEG procedures, including sleep recordings, in assessing the value of the EEG in the management of febrile seizures. The conclusion that EEG findings may lack predictive value for the later occurrence of epilepsy in children with febrile seizures has been based on longitudinal EEG investigations that were sometimes lacking in this necessary standardization and activation procedures, including sleep. Some earlier reports, omitted from the list of references cited in the present review, have demonstrated a predictive value for the EEG and later occurrence of afebrile seizures (Millichap JG. Febrile convulsions. Macmillan New York 1967). Further research would be justified.

PARENTAL REACTION TO FEBRILE CONVULSIONS

The parental reaction to a child's first febrile convulsion was investigated by telephone interview from the Department of Paediatrics, Randers Central Hospital, Denmark. Interviews were conducted in 52 cases from 3-20 months after the convulsion. Fear that the child would die during the fit was volunteered by 44% of parents and another 33% admitted the same reaction when specifically asked about it. Appropriate treatment, i.e. cooling the child and/or placing him in a side position was used in 63% of cases. The child was vigorously shaken during the seizure in 15%. Changes in the behavior of the parents following the child's first seizure included restless sleep in 60%, and dyspeptic symptoms in 29%. The frequency of parental behavioral symptoms rose dramatically if the child had more than a single fit. Many parents wished they had known more about fever and febrile convulsions in children. The general level of knowledge of febrile convulsions among parents of young children is low and the reaction of the parents to the first fit is often severe and persistent. Parents should be given written general information about fever and febrile convulsions, and information to parents who have witnessed a convulsion must be both verbal and written. It is concluded that parents of young children should be better informed about febrile convulsions before they occur. Well informed parents managed febrile convulsions better than those uninformed. (Balslev T. Parental reactions to a child's first febrile convulsion. A follow-up investigation. Acta Paediatr Scand April 1991; 80:466-469).

COMMENT. The controversy concerning the long-term prophylactic use of phenobarbital in the management of febrile seizures

and the consequent risk of a heightened prevalence of febrile seizure recurrence emphasizes the importance of parental education in the management of fever and febrile seizures. In the absence of a safe and satisfactory alternative to phenobarbital, parental anxiety may be allayed by the prescription of intermittent prophylactic treatment with diazepam at times of fevers but poor compliance minimizes its effectiveness in practice. The home use of rectal diazepam, employed more frequently in Europe than in the U.S., may offer an alternative method of parental involvement in selected cases.

HYPEREXPLEXIA OR HEREDITARY STIFF BABY SYNDROME

The stiff baby syndrome and its diagnostic distinction from epilepsy is reviewed from the Service de Neonatologie, Pavillon de la Mere et l'Enfant, Nantes, France. The disease hyperexplexia was first described in 1962 by Kok and Bruyn in 29 members of one family and occurred as a dominant autosomal transmission. It was distinguished by a permanent hypertonia that is heightened by the slightest stimulus. The hypertonia was noted at birth and became less pronounced during the first year of life but later could lead to repeated falls. The electromyogram showed persistent activity even at rest and the activity was abolished by diazepam. Lingam S, Wilson J, and Hart E named the condition "hereditary stiff baby syndrome" (Am J Dis Child 1981; 135:909). The child has a fixed stare and an expression of anxiety. The hypertonia diminishes during sleep and increases with the slightest psychic or tactile stimulus. Attacks of hypertonia may involve respiratory muscles and lead to apneas which can endanger the child's life. Digestive disorders including vomiting are usually associated with a hiatal hernia. The electroencephalogram is normal. (Tohier C et al. Hyperexplexia or stiff baby syndrome. Arch Dis Child April 1991; 66:460-461).

COMMENT. In addition to myoclonic epilepsy, the differential diagnosis includes the stiff man syndrome which is not hereditary but which may occur in children (Millichap JG, unpublished observation), the Isaacs-Mertens syndrome with distal hypertonia and fasciculations, the jumping Frenchmen of Maine syndrome with violent starts induced by slight stimuli and associated with echolalia and echopraxia, and Gilles de la Tourette syndrome. The pathology of stiff man syndrome has been localized to the spinal interneurons but the mechanism of hyperexplexia is controversial. Treatment with diazepam is effective.

POLYPHARMACOTHERAPY IN INSTITUTIONALIZED EPILEPTIC CHILDREN

An attempt to minimize polypharmacotherapy, to discontinue the use of phenobarbital, and to assess the relation between drug levels and antiepileptic effect in institutionalized severely retarded children is reported from the Department of Pediatrics, St. Goran's Hospital, Stockholm, and the Division of Clinical Pharmacology, University Hospital, Uppsala, Sweden. Nine severely mentally retarded patients