

with severe epilepsy were studied during a three year period by a multidisciplinary team. Combination therapy with two or three drugs gave the best antiepileptic effect and monotherapy was possible in only two patients. Phenobarbital withdrawal was possible in two of four patients. Regular phenytoin serum monitoring was necessary to avoid high levels that could be unnoticed for long periods and possibly result in chronic long-term side effects. (Ferngren H et al. Mono- or polypharmacotherapy in institutionalized epileptic children with severe mental retardation? A team approach for optimizing antiepileptic therapy. Acta Paediatr Scand April 1991; 80:458-465).

COMMENT. The tendency among neurologists to attempt conversion from polytherapy to monotherapy in severely retarded institutionalized patients may be hazardous and inadvisable. This study has demonstrated that polytherapy is frequently required. The recognition of anticonvulsant side effects may be more difficult in retarded patients compared to clinic patients and frequent serum drug monitoring is important.

COMBINATION PHENOBARBITAL/ANTIBIOTIC DRUG REACTIONS

Undesirable drug reactions during simultaneous administration of high dosage phenobarbital and beta lactam antibiotics, mainly Cefotaxim, are reported in 24 of 49 children admitted to intensive care at the Klinikum der J W Goethe Universitat, Frankfurt, Germany. The reactions were mainly exanthematous skin rashes which in some cases progressed to Stevens-Johnson syndrome. (Harder S et al. Unerwunschte Arzneimittelreaktionen bei gleichzeitiger Gabe von hochdosiertem Phenobarbital und Betalaktam-Antibiotika. Klin Padiatr Nov/Dez 1990; 202:404-407).

COMMENT. The incidence of skin reaction with phenobarbital is relatively rare compared to the anticonvulsants phenytoin and carbamazepine but the risk of serious skin reactions may be increased by the simultaneous administration of the antibiotic Cefotaxim.

TREATMENT ONSET AND EPILEPSY PROGNOSIS

The efficacy of treatment in relation to the lost time "tiempo perdido" in a group of 3529 epileptic patients was evaluated in the Division of Neurology and Clinical Neurophysiology, Hospital General du Cataluna, Barcelona, Spain. The mean follow-up period was ten years. The "lost time" is the period elapsed from the onset of symptoms and the beginning of long-term anticonvulsant treatment. In 970 patients with a lost time of less than a year, 86% were seizure-free whereas in 922 patients whose treatment was delayed greater than 11 years, 64% were seizure-free. Delay in starting anticonvulsant medication influenced the success of drug withdrawal. Of 710 patients who discontinued treatment, 315 (44%) had treatment initiated within one year of onset of seizures whereas drug withdrawal was possible in only 106 (15%) of the group in which treatment was delayed over 11 years. A total of 144 (20%) patients had seizure recurrences after drug withdrawal and of

this number, 14% occurred in the group treated early and 41% in the group with the longest period of delay in treatment. (Oller-Daurella L, Oller L F-V. Influence of the "lost time" on the outcome of epilep-sy. Eur Neurol May/June 1991; 31:175-177).

COMMENT. The sooner the correct diagnosis of epilepsy is made and treatment is begun, the fewer seizures a patient will suffer, and the greater the likelihood of successful antiepileptic control and subsequent withdrawal of antiepileptic drugs. Gowers, in 1881, pointed out that seizures beget seizures, and the greater the number of epileptic seizures the greater the likelihood of their continued reoccurrence. The results of this study should caution those who advocate delays in the initiation of anticonvulsant therapy and should encourage a more vigorous attempt to prevent seizure recurrences after the first epileptic seizure.

TONIC UPGAZE OF CHILDHOOD

A child with intermittent upward deviation of the eyes is reported from the Neuropediatric Unit CHUV, Lausanne, Switzerland. The boy was normal until nine months of age when brief intermittent upward eye deviation was noted and one month later these movements occurred for very long periods. At 14 months, vertical jerking of the eyes was associated with difficulty in downward gaze. He walked late at 16 months and fell often. When first examined at 21 months, the intermittent tonic upgaze lasted hours or days and was associated with a compensatory posture of the head, tilted with chin down. A downbeat nystagmus occurred when attempting to look down. His gait was wide-based and unsteady. The EEG, CT scan, NMR, and CSF exams were normal. The symptoms fluctuated and increased with fatigue and inter-current illness. They were less marked in the morning on awakening from sleep. Treatment with acetazolamide was without effect. When last seen at 39 months of age the abnormal eye movements and head posture had almost resolved and the ataxia was mild. Since age 18 months he had had episodes of cyanosis, loss of contact, hypotonia, and falling, sometimes triggered by an emotional situation and resembling breathholding spells. (Deonna T et al. Benign paroxysmal tonic upgaze of childhood - a new syndrome. Neuropediatrics Nov 1990; 21:213-214).

COMMENT. This syndrome was first described by Ouvrier RA and Billson MD (J Child Neurol 1988; 3:177-180). These authors reported four cases. Ahn and Hoyt reported three infants with a similar syndrome (See Ped Neur Briefs Jan 1989). The eye movements are not seizures and improvement following levodopa therapy in one child suggests a closer analogy with dopa-sensitive dystonia.

CNS NEOPLASMS

COGNITIVE DEFICITS IN BRAIN TUMOR SURVIVORS

The results of studies of cognitive deficits in long-term survivors of childhood brain tumors are summarized from 31 published