## FAT OVERLOAD FOCAL SEIZURES

Two 9-year-old patients receiving fat emulsion therapy (FET) who presented with focal seizures and other neurologic complications are reported from the Baylor College of Medicine, Neurology Service, Texas Children's Hospital, Houston, TX. FET (Intralipid) was administered during treatment of aplastic anemia by bone marrow transplantation in one and because of poor oral intake in another with cystic fibrosis. Focal seizures were associated with a hemiparesis, weakness, and altered mental status. CT of one child showed bilateral hypodensities, more prominent in one hemisphere. Both patients died of pneumonia. Autopsy findings included cerebral endothelial and intravascular lipid deposition, and multiple areas of necrosis and hemorrhage. (Schulz PE et al. Neurological complications from fat emulsion therapy. Ann Neurol May 1994;35:628-630). (Respond: Dr Schulz, Department of Neurology, NB-302, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030).

> COMMENT. A rapid rise in triglyceride levels may have contributed to the lipid deposition in brain endothelium and onset of seizures. Early recognition of the fat overload syndrome may allow prompt withdrawal of fat emulsion therapy and reversal of neurologic symptoms.

# HEADACHE

## INTERNATIONAL HEADACHE SOCIETY CRITERIA

A prospective study involving 72 children with recurrent headache, designed to determine whether the diagnosis of headache type made intuitively by each of 4 neurologists would have met the IHS diagnostic criteria, is reported from the Department of Pediatrics and Child Health, Children's Hospital and University of Manitoba, Winnipeg, and the Division of Pediatric Neurology, Children's Hospital, Calgary, Canada. The intuitive clinical diagnoses were as follows: migraine without aura (44 cases), migraine with aura (11), migraine and tension-type (11), tension-type (3), post-traumatic (2), and sinus (1). Features considered were location (unilateral or bilateral), quality (pulsating or pressing), intensity, exercise aggravation, nausea, vomiting, photophobia, phonophobia, and age. Dietary triggers were recognized in 8 of 44 children with migraine without aura, in 2 of 11 with migraine with aura, in 3 of 11 with combined migraine and tension headache, and in none with tension headaches. Family history of migraine in a first-degree relative occurred in 26 of 44 with migraine without aura, and 5 of 11 with migraine with aura. The intuitive diagnosis was completely concordant with the IHS criterion diagnosis in 61%, partially concordant in 31% and at complete variance in 8%. (Seshia SS et al. International headache society criteria and childhood headache. Dev Med Child Neurol May 1994;36:419-428). (Respond: Professor Shashi S Seshia, AE 208, Children's Hospital, 840 Sherbrook St, Winnipeg, Manitoba R3A 1S1, Canada).

> COMMENT. The authors concluded that the IHS criteria (1988), intended mainly for adults, can also be applied to children with recurrent headaches, but with some reservations. Revisions to the criteria should take into consideration the inability of children to describe the qualities and location of pain precisely. Children's reports of the quality of headache pain are variable and may be exaggerated in the 9 to 11 age group and minimized in the 6 to 8 year olds (see Ped Neur Briefs April

1991). Prevalence of migraine diagnosis by IHS criteria also favored Caucasian over African-American children, 61% to 35%, in a more recent study. Minority children were less likely to present with vomiting, lateralized pain, or food as a precipitant of headache. (Ped Neur Briefs Nov 1993). The IHS criteria should be modified to increase their sensitivity to children and adolescents and also to racial differences in symptomatology. (Progress in Pediatric Neurology II, Chicago, PNB Publ, 1994).

## CLUSTER HEADACHES RELIEVED BY INDOMETHACIN

The clinical features and treatment of cluster headaches are reported in two patients, a boy aged 8 and a girl 10 years, evaluated at the Department of Neurology, University of North Carolina at Chapel Hill. Indomethacin 25 mg bid produced immediate and complete relief. The headaches were sharp, unilateral, localized to the temporal region, and associated with lacrimation, nasal congestion, and photophobia. They occurred several times a day for 3 to 4 weeks, sometimes early morning, and lasted 10 minutes to 1 to 2 hours. Clusters were followed by a 2- to 3-week headache-free period. Trials of propanolol, amitryptyline, and biofeedback were unsuccessful. (D'Cruz OF. Cluster headaches in childhood. Clin Pediatr April 1994;33:241-242). (Respond: Dr D'Cruz, Univ of N Carolina, Burnett-Womack Bldg, CB #7025, Chapel Hill, NC 27599).

COMMENT. Cluster headaches are rare in children and are frequently atypical. Although remarkably effective in the two patients reported, indomethacin toxicity may limit chronic usage. Dietary factors in etiology might be considered.

# MOOD AND COGNITIVE DISORDERS

## DYSTHYMIA AND MAJOR DEPRESSIVE DISORDERS COMPARED

Clinical presentation, course, and outcome of childhood-onset dysthymic disorder (DD) in 55 school-age referrals were compared with a group of 60 youngsters whose first affective episode was major depressive disorder (MDD) in a prospective 3- to 12-year study at Psychiatric Departments of the University of Pittsburgh, Western Psychiatric Institute, University of California at San Diego, and Harvard Medical School. Dysthymic disorder was associated with earlier age at onset than MDD, similarly frequent symptoms of feeling unloved, friendless, irritability, anger, and self-deprecation, but relatively low rates of anhedonia (5% cf 70%), guilt (13% cf 30%), social withdrawal (8% cf 50%), impaired concentration (40% cf 67%), loss of appetite (5% cf 47%), insomnia (22% cf 62%), somatic complaints (36% cf 67%) and fatigue (22% cf 64%). Risk of affective disorders, including first-episode MDD (76%) and bipolar disorder (13%), was greater among dysthymic patients. After the first episode of MDD complicating DD, the clinical course of DD was similar to MDD in rates of recurrent major depression and bipolar disorder. In dysthymic children with subsequent MDD, the first episode of MDD is the "gateway" to recurrent affective illness. (Kovacs M et al. Childhood-onset dysthymic disorder. Clinical features and prospective naturalistic outcome. Arch Gen Psychiatry May 1994;51:365-374). (Reprints: Dr Kovacs, Western Psychiatric Institute and Clinic, 3811 O'Hara St, Pittsburgh, PA 15213).