COMMENT. The effect of 5-hydroxytryptophan was only partial, improving kinetic ataxic symptoms but not the static scores involving posture. In another double-blind crossover study at the Medical University of Lubeck, and other centers in Germany, Wessel K et al reported no significant effect of hydroxytrytophan on cerebellar symptoms in 19 patients with Friedreich's ataxia (Arch Neurol May 1995;52:451-455). Currier RD, in an editorial, concludes that "the levorotatory form of 5-hydoxytryptophan may have an effect that is minimal, selective, and difficult to detect. The question of clinical usefulness is not settled."

INFECTIOUS DISORDERS

BACTERIAL MENINGITIS OUTCOME

The neurologic, psychological, and educational outcomes of bacterial meningitis in 130 children evaluated at a mean age of 8 years, and 6 years after their meningitis, are reported from the Department of Paediatrics and Clinical Epidemiology and Biostatistics Unit, University of Melbourne, and the Royal Children's Hospital, Victoria, Australia. Compared to controls, children with meningitis as a group were at greater risk (26.9%) for abnormal neurologic and audiologic sequelae, had lower IQs and neuropsychologic performance, and behavior and adaptive difficulties at school. Eleven (8.5%) had major deficits (IQ <70, seizures, hydrocephalus, spasticity, blindness, or severe to profound hearing loss); and 24 (18.5%) patients compared to 14 (10.8%) controls had minor deficits (IQ 70-80, inability to read, some hearing loss, speech problems, and behavior disorders). Those who suffered acute neurologic symptoms with the meningitis had a poorer outcome than those with uncomplicated meningitis or controls (39% vs 18% vs 11%). (Grimwood K, et al. Adverse outcomes of bacterial meningitis in school-age survivors. Pediatrics May 1995;95:646-656). (Reprints: Dr Keith Grimwood, Royal Children's Hospital, Parkville, Victoria 3052, Australia).

COMMENT. Even with optimal treatment, one in four children who recover from meningitis may have severe or functionally significant disabilities which affect academic performance. The poor outcome is not restricted to those having acute neurologic complications. All children recovering from meningitis should be followed carefully until school age to exclude learning, hearing, and neurologic disorders that may require treatment.

PERINATAL HIV ENCEPHALOPATHY

The characteristics and survival of 178 children with perinatally acquired human immunodeficiency virus (HIV) infection and encephalopathy are reported from the Centers for Disease Control and Prevention, Public Health Service, US Department of Health and Human Services, Atlanta, GA. Ten percent of HIV-infected children and 23% of children with AIDS had HIV encephalopathy that was diagnosed at a median age of 19 months. The estimated risk of HIV encephalopathy by age 1 year was 4%, and by age 4 years it was 14%. HIV encephalopathy correlated with an increased risk of cardiomyopathy, more hospitalizations, and with severe immunodeficiency. Estimated median survival after diagnosis was 22 months. (Lobato MN et al.

Encephalopathy in children with perinatally acquired human immunodeficiency virus infection. J Pediatr May 1995;126:710-715). (Reprints: M Blake Caldwell MD, MPH, Division of HIV/AIDS, Centers for Disease Control and Prevention, 1600 Clifton Rd, MS E-45, Atlanta, GA 30333).

COMMENT. A recent American Academy of Neurology AIDS Task Force consensus report on nomenclature suggested that the term "HIV associated progressive encephalopathy of childhood" be adopted to replace AIDS encephalopathy and other terms used to describe the CNS abnormalities directly related to HIV-1 infection. (Neurology 1991;41:778-785). Belman AL reviews the recent advances in AIDS and the nervous system in Progress in Pediatric Neurology II (Millichap JG, Ed. PNB Publishers, 1994, pp397-400).

HEADACHE AND VASCULAR DISORDERS

CEREBRAL VEIN THROMBOSIS AND SYSTEMIC LUPUS

Three girls, ages 11, 14, and 17, with systemic lupus erythematosus, who had headache and were diagosed with cerebral vein thrombosis are reported from the Hospital for Sick Children, University of Toronto, and the Children's Hospital, McMaster University, Hamilton, Canada. Diagnosis was established by CT and MRI without need of angiography. Cerebral infarct occurred in one patient when diagnosis was delayed. All patients received low-dose oral anticoagulation and treatment for lupus and none had further thrombotic events during 10-18 month follow-up. (Uziel Y et al. Cerebral vein thrombosis in childhood systemic lupus erythematosus. J Pediatr May 1995;126:722-727). (Reprints: ED Silverman MD, Division of Rheumatology, The Hospital for Sick Children, 555 University Ave, Toronto, Ontario, Canada M5G 1X8).

COMMENT. Headache is the chief presenting symptom of cerebral venous thrombosis. These are of the tension or vascular type in 25%, but migraine headache and those associated with increased intracranial pressure also occur. Associated seizures, papilledema, and hemiparesis are also suggestive. A severe, persistent, throbbing headache, unresponsive to analgesics, points to a possible cerebral vein thrombosis, and is an indication for CT examination.

MIGRAINE AND ISCHEMIC STROKE

The relation between migraine and ischemic stroke in 72 young women aged under 45 and 173 controls was investigated at five hospital in Paris and suburbs. A questionnaire based on the International Headache Society's criteria for headache and migraine was used in telephone interviews. Migraine and ischemic stroke were strongly associated. Migraine was diagnosed in 60% of patients with stroke compared to 30% of controls. Women with migraine had a more than threefold increased risk of ischemic stroke (19 per 100,000 per year) compared with women without migraine (6 per 100,000 per year). The risk of stroke was higher in cases with aura than in those without aura. It was increased for migrainous women who used oral contraceptives or who were heavy smokers (>20 cigarettes/day). (Tzourio C et al. Case-control study of migraine and risk of ischaemic stroke in young women. BMJ 1 April 1995;310:830-833). (Respond: Dr Tzourio, INSERM U 360, Recherches Epidemiol en Neurologie et Psychopathologie, Cedex 94807 Villejuif, France).