EEG as well as any associated clinical seizures. Unfortunately, my success rate in a small number treated in Chicago cannot compare with that reported in the large series from Edinburgh. Benzodiazepines, the "fortnight drugs" (Dr Cynthia Stack's apt title), frequently lose effectiveness after 2 weeks, and ACTH has a high relapse rate.

**Language and motor reorganization following early left hemisphere lesions** was investigated using oxygen 15-water PET scans in 9 patients (aged 4-20 years) studied at Wayne State University Medical School, Detroit, MI ( Muller R-A, Rothermel RD, Chugani HT et al. Arch Neurol Aug 1998;55:1113-9). All patients had epilepsy and received antiepileptic medication. Regional cerebral blood flow was studied during rest, listening to sentences, repetition of sentences, and finger tapping of the right hand. Differential reorganizational patterns following early left hemisphere lesions found a greater potential for homotopic interhemispheric reorganization in language than in motor domains.

## CONCOMITANT ABSENCE AND ROLANDIC EPILEPSY

Of 80 children with absence epilepsy (CAE) and 42 with Rolandic epilepsy (BECCT), five (3 girls and 2 boys) had both syndromes, in a study at the University of Berne, Switzerland. All 5 patients had both generalized synchronous 3/sec spike and wave complexes and centrotemporal spikes in the EEGs, but the EEG finding did not always correspond with the clinical presentation. Only 2 patients showed both EEG patterns and both types of clinical seizures, absence and focal motor. Clinical manifestation of absences and partial motor seizures in the same patient is extremely rare. (Ramelli GP, Donati F, Moser H, Vassella F. Concomitance of childhood absence and rolandic epilepsy. Clin Electroencephalogr Oct 1998;29:177-180). (Reprints: Gian Paolo Ramelli MD, Division of Child Neurology, Department of Pediatrics, Inselspital, University of Berne, CH-3010 Berne, Switzerland).

COMMENT. My colleague, Dr Cynthia Stack (Director of Neurophysiology and Electroencephalography at Children's Memorial Hospital), is in agreement with the rarity of concomitant occurrence of these two common forms of epilepsy. She would prefer to see simultaneous EEG and video recordings to confirm the concomitant clinical manifestations of the syndromes, and questions whether the use of carbamazepine to treat the partial seizures might explain precipitation of a concurrent subclinical childhood absence syndrome. Video recordings were not included in the present series, and carbamazepine (CBZ) was employed in only one child who first presented with focal motor seizures and centrotemporal spikes in the EEG. A failed response to CBZ (at potentially toxic serum levels of 52 mg/L) was associated after 6 months with a change in the EEG to a synchronous generalized 3/sec spike and wave pattern, without clinical absence seizures. Replacement of CBZ with valproic acid was followed by clinical rolandic seizure control. All 5 patients responded to valproic acid.

The authors cite 9 previous reports of concomitant EEG findings (frequency usually 7-12% [25% and 73% in two small studies]) but only two reports (9 patients) of concomitant clinical absences with focal motor seizures in patients with benign rolandic epilepsy. Perhaps the clinical association of these syndromes might be diagnosed more frequently with simultaneous EEG and video recordings. The concurrence of generalized 3/sec spike and wave discharges with centrotemporal spikes in a child presenting with benign rolandic epilepsy should prompt greater hesitation in starting therapy. When treatment is considered essential, valproic acid would be a better choice than carbamazepine.