PSYCHOSOCIAL THERAPIES FOR CHRONIC HEADACHE

Psychosocial interventions in the management of recurrent headache disorders are reviewed from Ohio University, Athens, OH, and University of Mississippi Medical Center, Jackson, MS. The most frequently used interventions in adult patients are: 1) relaxation training, 2) biofeedback, 3) stress-management (cognitive-behavioral) therapy, and 4) dietary modification. Three types of relaxation training are employed: a) progressive muscle relaxation-alternately tensing and relaxing selected muscle groups, b) autogenic training-use of self-instructions of warmth and heaviness to promote relaxation, and c) meditation - use of a silently repeated word or sound to promote mental relaxation. Cognitive-behavioral interventions teach patients to identify stressful precipitants and strategies for coping with stress. Behavioral interventions yielded outcomes roughly equivalent to those obtained with propanolol in 60 clinical trials and 2400 patients with migraine. More than 50% improvement was obtained with either relaxation/biofeedback training or propanolol, compared to 14% with placebo and 3% if untreated. (Holroyd KA, Penzien DB. Psychosocial interventions in the management of recurrent headache disorders 1: Overview and effectiveness. Behav Med Summer 1994;20:53-62). (Reprints: Kenneth A Holroyd PhD, Dept of Psychology and Institute of Health and Behavioral Sciences, Ohio University, Athens, OH 45701).

> COMMENT. The management of headache in children is different from that of adults and requires an assessment of cognitive and affective development and a knowledge of children's concepts of illness and pain. The use of long-term investigational medications in children is often undesirable and relaxation techniques and dietary modification may be more effective and appropriate. (Ped Neur Briefs April 1991; Progress in Pediatric Neurology II, 1994, p 170).

CONGENITAL AND MENTAL RETARDATION SYNDROMES

WIEDEMANN SYNDROME

A boy, aged 2 years 5 months, with microcephaly, large anterior fontanelle, delayed psychomotor development, micropenis, and anomalies of thumbs and halluces is reported from the Department of Medical Genetics, Belfast City Hospital, Northern Ireland. From 9 months of age, he had generalized clonic convulsions, and at 18 months he developed minor seizures. An EEG at 13 months showed prominent delta activity and runs of low voltage fast, but no hypsarrhythmia or other seizure patterns. He was never able to sit and he had no speech. Muscle tone was increased, reflexes were hyperactive, and plantar responses extensor. Eye movements were roving. Fundi were normal. Head circumference was normal (50th centile) at birth and fell to below the 2nd centile within a year. Chromosome analysis showed a 46, XY karyotype. Renal ultrasound revealed an absent left kidney. CT of head at 22 months showed enlargement of all ventricles and cisterns and hypoplasia of the vermis. At 2 years 9 months he became comatose and he died at 3 years. Autopsy was refused. A maternal aunt had short broad thumbs, but no other congenital or genetic disorders were found in the family. Using the criteria microcephaly, short thumbs, micropenis, and mental retardation, the London Dysmorphology Database selected only Wiedemann's syndrome in diagnosis. Smith-Lemli-Opitz syndrome was also considered. (Nevin NC et al. Microcephaly with large anterior fontanelle, generalized convulsions,