6-mcg doses. Drowsiness occurred in 5 children, and 1 child developed dry mouth and anorexia Systolic blood pressure was lowered 3% with 4-mcg dose, 6.9% with 6-mcg, and 8.9% with 8-mcg doses. Clonidine was considered safe and effective in hyperkinetic children with mental retardation. (Agarwal V, Sitholey P, Kumar S, Prasad M. Double-blind, placebo-controlled trial of clonidine in hyperactive children with mental retardation. Mental Retardation August 2001;39:259-267). (Reprints: Dr Vivek Agarwal, B-1, 10/69 sector K-Aliganj, Lucknow-226024, India).

COMMENT. In this rather limited cohort of patients, the efficacy and safety of clonidine in the management of hyperactive, mentally retarded children has been demonstrated by controlled trial. Clonidine is a second line treatment for ADHD and is indicated primarily in patients with comorbid tics, oppositional defiance disorder, and sleep problems.

Hypoglycemic effect of clonidine. Four cases of hypoglycemia associated with clonidine stimulation of growth hormone secretion are reported from the Hospital for Sick Children, Toronto, Ontario (Huang C, Banerjee K, Sochett E et al. J Pediatr August 2001;139:323-324). Only one patient had growth hormone deficiency. Drowsiness after 0.15 mg/m^2 dose AM may prolong fasting and mask early signs and symptoms, leading to severe hypoglycemia. One patient aged 3 years had a generalized tonic-clonic seizure with a serum glucose of 2.3 mmol/L. EEG and head CT scan were normal.

Hypoglycemia is not a reported adverse reaction to clonidine in ADHD children, but blood sugar levels should be monitored in patients with suggestive symptoms. The PDR lists a transient *elevation* of blood glucose, not hypoglycemia, as a rare adverse reaction of clonidine.

VASCULAR DISORDERS

PRE- OR PERINATAL ARTERIAL ISCHEMIC STROKE

Risk factors, coagulation profiles, and outcomes in 22 children with presumed perinatal infarct were studied at The Hospital for Sick Children, Toronto, and Chedoke McMaster Hospital, Hamilton, both participants in the Canadian Pediatric Ischemic Stroke Registry. Criteria for inclusion were the following: 1) normal neonatal neurological history, 2) hemiparesis and/or seizures first recognized after two months of age, and 3) CT or MRI showing remote cerebral infarct. Median age at presentation was 6 months. Median age at last visit was 4 years (range, 8 months to 16.5 years). Eighteen of 22 mothers had gestational or obstetrical risk factors, including preeclampsia (4), maternal infection (4), gestational diabetes (3), premature delivery, bleeding, and breech presentation. Fourteen children had coagulation abnormalities including anticardiolipin antibody (ACLA) in 12, and activated protein C resistance (APCR) in 3. Six had a family history of thrombosis. Echocardiograms were normal. Hemiparesis, right sided in 14, persisted in all patients, 12 had speech, behavior, or learning problems, and 5 had persistent seizures. Stroke did not recur, despite persistence of ACLA or other clotting abnormalities. (Golomb MR, MacGregor DL, Domi T et al. Presumed pre- or perinatal arterial ischemic stroke: risk factors and outcomes. Ann Neurol August 2001;50:163-168). (Respond: Dr Gabrielle A deVeber, Division of Neurology, The Hospital for Sick Children, 555 University Ave, Toronto M5G 1X8, ON, Canada).

COMMENT. ACLA is a risk factor for ischemic stroke in the fetus and neonate, and recognition of hemiparesis may be delayed to age 6 months or later.