literature over 3 decades (1934-64) of 3,168 patients reported in 13 publications, roseola infantum was the cause of febrile convulsions in 4% (range 0.6 - 7.6%). The average incidence of convulsions among 581 patients with roseola infantum reported in 11 publications was 22%. The evidence for an encephalitie process such as CSF pleocytosis was lacking except for a rare case and the height of the body temperature that usually accompanies roseola infantum was considered sufficient to explain the frequent complication of convulsions (Millichap JG, Febrile Convulsions, 1968, Macmillan, New York). The present report of HHV-6 infection associated with roseola infantum supports the theory of an encephalitie illness in the etiology of the seizure. Inclusion of roseola infantum as a cause of simple febrile seizures must be reevaluated in the light of this report.

HERPES SIMPLEX VIRUS ENCEPHALITIS

The difficulties in diagnosis in 6 children aged 13 days to 9 years with herpes simplex encephalitis (HSE) are stressed in a report from the Departments of Child Health and Pathology, University Hospital of Wales, Cardiff. The original diagnoses in 3 cases were post-traumatic epilepsy, bacterial meningitis and febrile convulsion. Fever was absent in 2 cases and the CT was normal in 2. All cases had abnormal EEG findings with encephalitic changes in 5. Brain biopsy was diagnostic in 2. The outcome was poor in all 6. The authors stress that the absence of fever at presentation and a normal CT scan should not discourage the use of acyclovir for children presenting with focal seizures and altered consciousness (Cameron PD et al. Herpes simplex virus encephalitis: problems in diagnosis. Dev Med Child Neurol Feb 1992; 34:134-140). (Correspondence: S.J. Wallace, Department of Child Health, University Hospital of Wales, Heath Park, Cardiff CF4 4XW, Wales.)

COMMENT. Mikati MA and colleagues at the Children's Hospital and Massachusetts General Hospital, Boston have shown that the EEG is a sensitive test that may be superior to radiologic procedures in the early diagnosis of neonatal herpes simplex encephalitis. The multifocal periodic pattern in the presence of CSF pleocytosis is highly suggestive of the diagnosis. The CT and ultrasound studies may be normal when the EEG is abnormal during the first few days of the infection. An MRI with T2 weighted images may be more revealing than the CT and will show multiple small disseminated lesions (see **Progress in Pediatric Neurology**, 1991, p. 423, PNB Publishers).

PRE-ERUPTIVE VARICELLA ENCEPHALITIS AND CEREBELLAR ATAXIA

A 2 year old boy who developed varicella encephalitis with cerebellar ataxia 16 days before the appearance of the exanthem is reported from the Department of Neurology, Children's Hospital, Harvard Medical School, Boston, MA. The child was previously healthy, but had been exposed to his 5 year old brother who had developed varicella 4 days previously. The serum varicella-zoster IgG was absent on admission and 69.6 ELISA units/ml 5

weeks later (Liu GT, Urion DK. Pre-eruptive varicella encephalitis and cerebellar ataxia. Pediatr Neurol Jan/Feb 1992; 8:69-70). (Correspondence: Dr. Urion, Department of Neurology, Children's Hospital, 3010 Longwood Ave., Boston, MA 02115.)

COMMENT. Pre-eruptive neurologic complications of varicella are rare but the diagnosis should be considered in children presenting with cerebella ataxia. The authors kindly cite a reference to my own experience at the Mayo Clinic and a report of a 5 year old boy presenting with symptoms and signs of intracranial hypertension and cerebellar ataxia which antedated the exanthema by 11 days (Goldston AS, Millichap JG, Miller RH. Cerebellar ataxia with pre-eruptive varicella. Am J Dis Child 1963; 106:197-200). In our patient the fundoscopic examination disclosed bilateral papilledema and a right sixth nerve palsy that led to ventriculography to exclude a space occupying lesion. In 15 previous reports of pre-eruptive neurologic complications of varicella, cerebellar ataxia was mentioned only in 1.

MIGRAINE AND OTHER HEADACHES

HEADACHE AND CHIARI TYPE I MALFORMATION

Headache was the presenting symptom in 5 of 6 patients with Chiari type malformation, reported from the Departments of Neurology and Neurosurgery, Trondheim University Hospital, Norway. Patient 1 had migraine headaches that started at age 22 during a first pregnancy. Patients 2 and 3, monozygotic twin daughters of patient 1, had headache and diplopia or vertigo, starting either at puberty or after the birth of a first child at the age of 20 years. Patients 4 and 5, daughters of patients 2 and 3, had pain in the neck and head. The diagnosis was made by MRI and confirmed at the time of surgery in 1 twin. The mother of patient 1 had severe headaches of undetermined cause. Whooping cough at the age of 2 weeks may have accentuated the degree of cerebellar herniation in 1 twin (Stovner LJ et al. The Chiari type I malformation in two monozygotic twins and first-degree relatives. Ann Neurol Feb 1992; 31:220-222). (Correspondence: Dr. Stovner, Department of Neurology, Trondheim University Hospital, 7006 Trondheim, Norway.)

COMMENT. Chiari type I malformation should be considered in the diagnosis of headache presenting at puberty or during first pregnancies. Hormonal changes may accentuate the tonsillar herniation and precipitate the occurrence of symptoms. A herniation of at least 5 mm is clearly pathological and 3-5 mm represents a borderline zone. The significance of minor degrees of herniation in adolescents with recurrent migraine type headaches is a concern and requires careful follow-up.

Chiari type I malformation was the cause of a velopharyngeal insufficiency in a 5 year old girl reported from the Hopital Robert Debre, Paris, France (Gerard CL. Dev Med Child Neur Feb 1992;