EPILEPSY WITH OCCIPITAL PAROXYSMS

A 15 year prospective study of 18 children with benign childhood epilepsy with occipital paroxysms was carried out at the Division of Neurology and Clinical Neurophysiology, King Khalid University Hospital, Riyadh, Saudi Arabia. These patients represented one-fifth of all benign age-and localization-related idiopathic epilepsies seen with onset before the age of 13 years. There was a preponderance in females and peak age at onset was five years. The seizures consisted of tonic deviation of the eyes and vomiting, followed by unilateral or generalized convulsions. They were mainly nocturnal. Remission usually occurred one to two years after onset and no seizures occurred after 12 years of age. Two children were exceptional, having frequent diurnal episodes with visual hallucinations, postictal headache, and occasional nocturnal hemiconvulsions. EEG abnormalities consisted of repetitive spike and slow-wave discharges in the occipital regions, attenuated with eyes open. The EEG abnormalities persisted after clinical remission, sometimes up to age 16. (Panayiotopoulos CP. Benign childhood epilepsy with occipital paroxysms: a 15-year prospective study. Ann Neurol July 1989; 26:51-56).

COMMENT. The authors propose a definition of benign childhood epilepsy with occipital paroxysms as follows: a syndrome of brief or prolonged partial seizures marked by deviation of the eyes and vomiting. The seizures are usually nocturnal and frequently evolve to hemiconvulsions and generalized tonic-clonic fits. Onset is between the ages of two and eight years, with a peak occurring at five years and remission before 12 years. There is a preponderance in females and prognosis is excellent. In addition, there is a late onset variant with mainly diurnal seizures consisting of visual symptoms often followed by hemiclonic seizures or automatisms and migraine headache. Prognosis appears relatively good. The EEG in both shows repetitive occipital spikes/sharp and slow waves that are often asymmetrical and which attenuate or disappear when the eyes are open.

This syndrome is related to basilar migraine with epileptiform EEG abnormalities (Camfield PR, Metrakos K, Andermann F. Neurology 1978; 28:584).

REVISED CLASSIFICATION OF EPILEPSIES

The proposals for a revised classification of epilepsy and epileptic syndromes (1981-1985) have again been revised by the Commission on Classification and Terminology of the International League Against Epilepsy. The major classes are I. generalized epilepsy, and II. localization related, partial or focal epilepsies. Epilepsies of known etiology (symptomatic or secondary "epilepsies" are separated from idiopathic (primary) and cryptogenic. Idiopathic epilepsies are distinguished from cryptogenic epilepsies. Idiopathic epilepsies are defined by age related onset, clinical and electroencephalographic characteristics and a presumed genetic etiology. Cryptogenic epilepsies are presumed to be symptomatic and the etiology is unknown; they are age related but often do not have well defined electroclinic characteristics.

In addition to the localization related and generalized epilepsies and syndromes there are III. unclassified epilepsies, and IV. special syndromes, e.g. febrile convulsions. There are two appendices to the revised classification. 1. Symptomatic generalized epilepsies of specific etiologies including malformations and inborn errors of metabolism and Appendix 2 precipitated seizures, e.g. reflex epilepsies, startle epilepsy, and primary reading epilepsy. (Commission on Classification and Terminology of the International League Against Epilepsy. Proposal for revised classification of epilepsies and epileptic syndromes. Epilepsia July/August 1989; 30:389-400).

> COMMENT. The Commission recognizes that the revised classification is not totally satisfactory. Patients may move from one syndrome to another during the evolution of the epilepsy, e.g. a child with West syndrome may later satisfy the criteria for the Lennox-Gastaut syndrome. It is of interest that the Commission is reverting to the older traditional concept of an idiopathic "primary" epilepsy of presumed genetic etiology as separate from the cryptogenic epilepsies presumed to be symptomatic. Criticisms of the new classification not stressed by the Commission are as follows: 1) The grouping of seizure patterns proposed are at variance with therapeutic correlations, e.g. absence and tonic-clonic seizures grouped together as generalized epilepsies require different types of medication for their control, and 2) The oversimplification and emphasis of syndromes might lead to a decreased awareness of etiologies and misdiagnoses of underlying pathologies.

DRUG-INDUCED SEIZURES

Recreational drug-induced seizures in 47 patients seen at the San Francisco General Hospital between 1975 and 1987 were reported by the Division of Clinical Pharmacy and Department of Neurology, University of California, San Francisco, CA. Over the twelve year study period 49 episodes of seizures followed the use of most of the popular street drugs and were seen after ingestion, snorting, smoking and injection. The average age of the 28 men and 19 women was 27 years (range 19-42 years). The majority of patients experienced a single generalized tonic-clonic seizure but seven had multiple seizures and two developed status epilepticus. The recreational drugs were cocaine (32), amphetamines (11), heroin (7), and phencyclidine (4). A combination was responsible in 11. Seizures occurred independent of the route of administration and in both first-time and chronic abusers. Ten (21%) had prior seizures, all closely associated with drug abuse. Apart from the patient with status epilepticus, none had permanent neurologic impairment at the time of discharge from hospital. (Alldredge BK et al. Seizures associated with recreational drug abuse. Neurology August 1989; 39:1037-1039).

> COMMENT. Although the patients in this study were adults, the possibility of drug abuse should be considered in the evaluation of infants, children and adolescents with seizures. Heroin withdrawal has been associated with seizures in neonates (Herzlinger RA et al. J Pediatr 1977; 91:638) but not in older patients. It is fortunate