with severe epilepsy were studied during a three year period by a multidisciplinary team. Combination therapy with two or three drugs gave the best antiepileptic effect and monotherapy was possible in only two patients. Phenobarbital withdrawal was possible in two of four patients. Regular phenytoin serum monitoring was necessary to avoid high levels that could be unnoticed for long periods and possibly result in chronic long-term side effects. (Ferngren H et al. Mono- or polypharmacotherapy in institutionalized epileptic children with severe mental retardation? A team approach for optimizing antiepileptic therapy. Acta Paediatr Scand April 1991; 80:458-465).

COMMENT. The tendency among neurologists to attempt conversion from polytherapy to monotherapy in severely retarded institutionalized patients may be hazardous and inadvisable. This study has demonstrated that polytherapy is frequently required. The recognition of anticonvulsant side effects may be more difficult in retarded patients compared to clinic patients and frequent serum drug monitoring is important.

COMBINATION PHENOBARBITAL/ANTIBIOTIC DRUG REACTIONS

Undesirable drug reactions during simultaneous administration of high dosage phenobarbital and beta lactam antibiotics, mainly Cefotaxim, are reported in 24 of 49 children admitted to intensive care at the Klinikum der J W Goethe Universitat, Frankfort, Germany. The reactions were mainly exanthematous skin rashes which in some cases progressed to Stevens-Johnson syndrome. (Harder S et al. Unerwunschte Arzneimittelreaktionen bei gleichzeitiger Gabe von hochdosiertem Phenobarbital und Betalaktam-Antibiotika. Klin Padiatr Nov/Dez 1990; 202:404-407).

COMMENT. The incidence of skin reaction with phenobarbital is relatively rare compared to the anticonvulsants phenytoin and carbamazepine but the risk of serious skin reactions may be increased by the simultaneous administration of the antibiotic Cefotaxim.

TREATMENT ONSET AND EPILEPSY PROGNOSIS

The efficacy of treatment in relation to the lost time "tiempo perdido" in a group of 3529 epileptic patients was evaluated in the Division of Neurology and Clinical Neurophysiology, Hospital General du Cataluna, Barcelona, Spain. The mean follow-up period was ten years. The "lost time" is the period elapsed from the onset of symptoms and the beginning of long-term anticonvulsant treatment. In 970 patients with a lost time of less than a year, 86% were seizure-free whereas in 922 patients whose treatment was delayed greater than 11 years, 64% were seizure-free. Delay in starting anticonvulsant medication influenced the success of drug withdrawal. Of 710 patients who discontinued treatment, 315 (44%) had treatment initiated within one year of onset of seizures whereas drug withdrawal was possible in only 106 (15%) of the group in which treatment was delayed over 11 years. A total of 144 (20%) patients had seizure recurrences after drug withdrawal and of