investigated at Helsinki University Hospital, Finland. An analysis of 204 EEG recordings from 98 consecutive acyclovir-treated patients with acute encephalitis found that, in the acute phase, clinical epileptic seizures, and focal abnormalities and periodic complexes in the EEG, but not diffuse background slowing, were predictive of a poor outcome. In follow-up EEG recordings, diffuse slowing was significantly associated with poor outcome. The EEG is valuable in assessment of progression in the level of consciousness and epileptic activity in the unconscious patient with encephalitis. (Siren J, Seppalainen A-M, Launes J. Is EEG useful in assessing patients with acute encephalitis treated with acyclovir? Electroenceph clin Neurophysiol Oct 1998;107:296-301).

Of interest, the neonate in the above Japanese study, whose neurologic exam had returned to normal one week after the onset of convulsions and the acute phase of enterovirus 71 meningoencephalitis, had repeated EEGs revealing no abnormalities. The developing motor disorder at several months follow-up could be explained as a lower motor neuron poliolike muscle weakness.

HIV INFECTION PRESENTING WITH STROKE AND SEIZURES

Two children, ages 2 years and 2 months, presenting with acute hemiparesis and focal seizures as the initial manifestations of human immunodeficiency virus (HIV) infection are reported from Ramathibodi Hospital, Mahidol University, Bangkok, Thailand. CT in the 2-year-old with hemiparesis showed acute infarction of the right thalamus and internal capsule, and old infarction with bilateral basal ganglia calcification and cerebral atrophy. MRI revealed narrowing of the right middle cerebral artery. The 2-month-old infant with a one week history of multiple focal seizures and impaired consciousness was jaundiced, and the CT revealed hemorrhagic infarction of the right cerebral hemisphere, with acute intraparenchymal bleeding. MRI showed narrowing and irregularity of the right middle cerebral and internal carotid arteries. HIV infection was documented only after the onset of acute neurologic manifestations. Neither coagulopathy nor other cause of stroke was identified. Tests for opportunistic infections were negative. (Visudtibhan A, Visudhiphan P, Chiemchanya S. Stroke and seizures as the presenting signs of pediatric HIV infection. Pediatr Neurol Jan 1999;20:53-56). (Respond: Dr Anannit Visudtibhan, Department of Pediatrics, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok 10400, Thailand).

COMMENT. Stroke may be the first clinical manifestation of HIV infection in infants and young children. A test for HIV should be included in the work-up of cases of stroke in children at risk of HIV infection.

My colleague, Dr Leon Epstein, Head of the Division of Neurology, Children's Memorial Hospital, Chicago, has written extensively on the neurologic manifestations of HIV infection in children (In Pediatrics 1986;78:678-687, and other subsequent publications). A progressive encephalopathy is reported most commonly. In his experience, seizures are not a prominent symptom of HIV infection, and opportunistic infections, including measles, must be excluded as possible alternative causes of neurologic manifestations.

In a study reviewed in Ped Neur Briefs (June 1998;12:44), Cooper ER et al. report encephalopathy in 21% of 128 HIV-perinatally infected children, with a mortality of 41%. Failure to gain weight predated the onset of encephalopathy in infected infants. A high viral load during infancy, failure to thrive, and early signs of hepatomegaly and lymphadenopathy are risk factors for HIV

encephalopathy. The 2-month-old infant in the Bangkok study had a low birth weight and hepato-splenomegaly, while the 2-year-old was reported to have a normal development up to the onset of stroke.

SSPE AND NEONATAL MEASLES

A case of subacute sclerosing encephalitis in a child, aged 3 years 6 months, who had contracted measles from his mother on day 27 as a neonate, is reported from Akita University School of Medicine, Japan. He presented with acute cerebellar ataxia which gradually improved, but mental deterioration and head nodding developed. The EEG showed diffuse slowing and periodic discharges that synchronized with the nodding. Measles antibody titers in the CSF and serum were abnormally elevated. MRI showed diffuse high intensity T2-weighted images in the white matter. Treatment with oral isoprinosine and intraventricular interferon failed to stem the relentless progression to a bedridden, mute stage within 3 months. This was followed by a plateau and later, a gradual but limited clinical improvement and MRI evidence of progressive cerebral atrophy. (Sawaishi Y, Abe T, Yano T, Ishikawa K, Takada G. SSPE following neonatal measles infection. Pediatr Neurol Jan 1999;20:63-65). (Respond: Dr Yukio Sawaishi, Department of Pediatrics, Akita University School of Medicine, Hondo 1-1-1, Akita 010-8543, Japan).

COMMENT. Measles virus infection under 1 year of age is a risk factor of SSPE. Immaturity of the brain at the time of measles infection may predispose to the SSPE.

ATTENTION AND COGNITIVE DISORDERS

ADHD AND COMORBID COORDINATION DISORDER

The cooccurrence of attention deficits and motor incoordination or clumsiness was examined at the University of Goteborg in a population study of 400 seven-year-old children attending mainstream schools in Karlstad, Sweden. ADHD, developmental coordination disorder (DCD), and combined deficits in attention, motor control, and perception (DAMP) were found in 6.1%. Severe ADHD alone occurred in 2% and moderate ADHD in 5.4%. The boy:girl ratio was 2:1 for severe DAMP and 6.2:1 for severe ADHD alone. Considerable overlap of attention deficits and motor clumsiness was present. One half the children with ADHD had moderate motor incoordination (DCD), and one in 5 was severely affected. Similarly, children with DCD frequently met criteria for the diagnosis of ADHD. Findings were unchanged at follow-up examinations 8 months later. 'Soft signs' were highly reproducible, with excellent agreement between neurologic exams and observations of motor dysfunction reported by physical education teachers. Parent reports of ADHD were confirmed by teacher observations in more than 90% of cases, whereas 40% of teacher diagnoses of ADD were not reported by parents in the home setting. DSM-III-R criteria for ADHD tended to exclude many ADD children with a high degree of classroom dysfunction. Those with subtype ADD or DAMP had higher classroom-dysfunction scores than those with mainly hyperactivity or ADHD. DAMP is a valid diagnostic subtype of ADHD. (Kadesjo B, Gillberg C. Attention deficits and clumsiness in Swedish 7-year-old children. Dev Med Child Neurol Dec 1998;40:796-804). (Respond: Christopher Gillberg MD PhD, Department of Child and Adolescent Psychiatry University of Goteborg, Sahlgren University Hospital, S-41345, Goteborg, Sweden).

COMMENT. A neurologic examination to uncover soft signs, motor