Age and maturity, changes in the balance of water and electrolytes in the brain, and various drugs were factors found to modify the threshold convulsive temperature in young animals. An antihistamine, diphenhydramine and the anticonvulsant, phenytoin lowered the threshold convulsive temperature and exacerbated fever-induced seizures, whereas phenobarbital and phetharbital elevated the threshold and prevented seizures. (Millichap JG. Febrile Convulsions, Macmillan, New York, 1968). See Progress in Pediatric Neurology II, 1994, pp16-32, and I, 1991, pp14-24, (edited by Millichap, PNB Publishers) for a compendium of more current articles on febrile seizures.

SUPPLEMENTARY SENSORIMOTOR SEIZURES

The diagnosis, clinical features, video EEG and MRI findings, medical and surgical treatment, pathology, and prognosis in eleven children and adolescents with supplementary sensorimotor area seizures (SSMA) are reported from the Departments of Neurology, Neurosurgery, and Radiology, Cleveland Clinic Foundation, Cleveland, Ohio. Mean age at onset was 5.8 years, and the diagnosis was made by vertex sharp waves on prolonged video EEG (3 to 7 days) at a mean age of 12 years. Neurologic exam was normal, except for 2 patients with a focal decrease in hand coordination, and routine EEGs were frequently normal. Seizures were usually bilateral and tonic, affecting proximal limb muscles, frequent, occurring daily, refractory to medication, without loss of cosciousness, and mainly during sleep. MRI revealed a low-grade tumor or focal cortical dysplasia in 5 patients. Six had cortical resection after confirmation of SSMA by subdural EEG, and 5 were benefited. (Bass N, Wyllie E et al. Supplementary sensorimotor area seizures in children and adolescents. J Pediatr April 1995;126:537-544). (Reprints: Elaine Wyllie MD, Head, Pediatric Epilepsy Program, Cleveland Clinic Foundation, Desk S51, 9500 Euclid Ave, Cleveland, OH 44195).

COMMENT. SSMA seizures differ from generalized TC seizures in preservation of consciousness, and from perirolandic benign focal epilepsy of childhood in bilaterality and proximal gross flailing movements. Preserved consciousness and gross bilateral, proximal limb movements are the principal distinguishing features of SSMA. Brevity and nocturnal predominance are other characteristic features. Prolonged video EEG and MRI are important in diagnosis, and surgery should be considered in refractory patients. The neuropsychological and behavioral abnormalities often found in adolescents with frontal lobe seizures or damage (see Progress in Pediatric Neurology I, 1991, p71, and Vol II, 1994, p180-3) were not evident in these patients with lesions in the supplementary SM area. Auras and sensory manifestations may be more difficult to elicit in children than in adults. Auras in 5 of the above patients included crawling, tingling or heavy sensations of the limbs and one complained of epigastric discomfort. Similar sensations were described in case reports of Penfield W, and Jasper H. Epilepsy and the Functional Anatomy of the Human Brain. Little, Brown, Boston, 1954, p398.

REFLEX MYOCLONIC EPILEPSY OF INFANCY

Six neurologically normal infants, aged 6-21 months, with attacks resembling benign myoclonic epilepsy of infancy but occurring as reflex