

Abstracts

An audit of children referred with suspected epilepsy

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Members of the British Paediatric Neurology Association were invited to participate in a national audit of children presenting with a possible diagnosis of epilepsy. The primary objectives of this audit were to identify whether a 'standard' or set of predetermined criteria was being met when assessing children presenting with suspected epilepsy at their first new outpatient visit, and specifically to determine whether an adequate history was obtained when diagnosing and classifying epilepsy. An additional aim was to assess the level of information within the medical case notes. This 'standard' or set of predetermined questions was comprised by an advisory audit group. The audit form comprised a total of 30 questions divided into sections addressing history, examination, investigation, treatment, and communication. Information for the audit was obtained retrospectively from the child's case notes. Each participating centre or consultant was asked to audit the case notes of 20 children. At the end of the 12-month recruitment period, three centres responded, contributing audit forms on 50 children. The required information was provided for most questions in each section, thereby meeting the audit standard. Within the history section, only 32 of the 50 (64%) case notes had recorded whether the episode had been prompted by an obvious provoking factor or circumstance. In 35 cases (70%) there was a statement about the child's neurological development in the first 2 years of life. The specific epilepsy diagnoses were made in 45 children, these being: primary (idiopathic) generalized epilepsy, six children (12%); symptomatic generalized epilepsy, three children (6%); benign partial epilepsy, one child (2%); myoclonic epilepsy, one child (2%); infantile spasms, one child (2%); partial seizures (<1 seizure/month), six children (12%); and partial seizures (>1 seizure/month), 19 children (38%). Three other seizure 'types' were also identified: 'photoconvulsive generalized epilepsy' (2%), 'petit mal' (2%), and a 'complicated febrile convulsion' (2%). It was not possible to identify the specific seizure type in four children.

The children in the study had the following investigations: all 50 children (100%) had either already had or were about to have an EEG; 22 children (44%) had undergone or were about to have a CT head scan; 23 children (46%) had undergone or were about to have an MRI head scan.

Over 90% of audit forms included a comment on the child's current antiepileptic treatment, including dosage. Communication was the least satisfactorily completed section with between none and 48% of the case notes documenting that the child's family had been informed of the existence of a voluntary epilepsy organization. Despite the simplicity of the audit form, the response for this national audit was considerably lower than anticipated.

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Effects of sleep position on infant motor development

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In 1992, the American Academy of Pediatrics (AAP) published a recommendation that 'healthy infants, when being put down for sleep, be positioned on their side or back' in an attempt to decrease the incidence of sudden infant death syndrome (SIDS). Since this recommendation, the percentage of infants sleeping prone has decreased dramatically. With the increase in supine sleeping, paediatricians have questioned whether there are differences in the rate of acquisition of early motor milestones between prone and supine sleeping infants.

To examine this question, this study reports a prospective, practice-based investigation of healthy term infants living in Washington, DC. Parents were asked to record their infants' sleep position and awake time spent prone until 6 months of age. A developmental log was used to track milestones from birth until the infant was walking. A research assistant telephoned the families monthly to record the age of attainment of milestones and to remind parents to keep the sleep-position and developmental log up to date. An independent assessment of health, growth, and development was performed by paediatricians at each well-child check, including a specific statement at the infant's 12-month visit, saying that the infant is healthy and neurologically normal at 12 months of age. Infants were enrolled in the study before the age of 1 month and parents were provided with a brochure and advised to place their infant on the side or back for sleep according to the AAP recommendation. Despite this advice, 12% of the 2-week-old infants in the study were being placed prone for sleep and this number increased to 32% by 6 months of age. Ages of acquisition of eight motor milestones were determined and the mean ages of milestone attainment of prone and supine sleepers were compared. Three hundred and fifty-one infants completed the study. Prone sleepers acquired motor milestones at an earlier age than supine sleepers. There was a significant difference in the age of attainment of rolling prone to supine, tripod sitting, creeping, crawling, and pulling to stand. There was no significant difference in the age when infants walked.

The study suggests that the pattern of early development is affected by sleep position. Prone sleepers attain several motor milestones earlier than supine sleepers. However, all infants achieved all milestones within the accepted normal range. Paediatricians can use this information to reassure parents that this difference in milestone attainment is not a reason to abandon the current sleep-position recommendations.

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