

Joanne Dahl's book, although relating to children, does provide such practical information. As a newcomer to the subject I found the book extremely useful in a practical sense because it is clear and logical: it took me through the behavioural management of epilepsy from start to finish.

I felt it could have been more concise as there was considerable repetition in the early chapters where I felt the author was concentrating on trying to win over the reader and constantly justifying the treatments. Although perhaps there are still obtuse people who refuse to recognize the psychological aspects of epilepsy, the person who will be using this book for practical help will already have some conviction that behavioural therapy is useful and will be much more concerned with a clear description of the various methods of treatment.

At the point in the book where behavioural analysis and methods of treatment are discussed, the book becomes much more useful and gave me the confidence that I needed. By the end of the book I certainly had accepted the author's viewpoint that 'almost every child/patient with epilepsy can influence his or her seizure development to some degree'. The patient I was treating was an adult but the principles in this book, although directed towards children, are equally applicable to adults. For someone who is wanting to learn how to use these methods this book is invaluable and I thoroughly both enjoyed reading it and using it.

Overall, both these books were valuable—the first one particularly for reference and for giving me ideas and the second one for an extremely practical and helpful approach to behavioural treatment in epilepsy. It is a pity that the title of the second book, which seems to imply that it is purely about children, will prevent some people from using it.

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EPILEPSIES OF CHILDHOOD. N. O'Donohoe, Third Edition. Oxford, Butterworth and Heinemann 1994.

This is the third edition of an extremely well-known, well-loved textbook designed for the general paediatrician, and other doctors without specialist knowledge of epilepsy, who need to understand the management of childhood epilepsies. It succeeds admirably. I have used the previous editions to keep in touch with what our paediatric colleagues are up to and to delve into the mysteries of the child with epilepsy. I shall certainly use this edition in the same way and with the same enjoyment. It is packed full with the author's own experience (but without the blind spots that single author texts often have) and is extremely well-referenced pointing the reader in the right direction for fuller understanding of the topic under discussion.

The book covers a wide area from the neonate with

epilepsy to early adult life and there is a rich subtext of psychological and social information and advice about managing the child and adolescent with epilepsy and the family that has to live and cope with the epilepsy.

It is a reflection on the rapid progress that is taking place, both in paediatric and adult epilepsy at the moment, that sections of the book are already out of date, rather than a reflection on the author. Views on the management of infantile spasms (concerning the diminishing role of steroids and the increasing importance of Vigabatrin) have already changed since the author wrote his chapter and his cautious description of the possible uses of Lamotrigine in paediatrics has since been overtaken by further experience. Most authorities would also now agree that with the advent of more high powered MRI machines with faster acquisition times this technique has become the investigation of choice in childhood epilepsy.

Two topics that concern many doctors who deal with the aftermath of childhood epilepsy are scarcely mentioned. The first is the vexed topic of when, in children, it is safe to withdraw anticonvulsant medication. This particularly needs to be discussed because paediatric and adult epileptologist's views differ and the experimental evidence in children is much less clear than it is with adults. There is a mention of this in the chapter on the adolescent with epilepsy, but I do think it could have been more emphasized.

The second topic is the issue of when childhood epilepsy ceases to be childhood epilepsy and becomes the province of the adult specialist? Professor O'Donohoe's practice starts at the year zero and seems to continue into the twenties. Some discussion and guidance as to when a patient should be handed over to the adult services would have been useful. Since there is a chapter on adolescent epilepsy with a brief mention of some of the problems of the adolescent (in terms of secondary schooling, further education, compliance with medication etc.), the implication is that the changeover should occur at some point in the adolescent process and I would be interested in Professor O'Donohoe's views as to how this transition is arranged and when it should occur.

Although the rapid progress taking place in epilepsy management will make some of the information expressed in this book obsolete it will not take away from it the seam of experience and humanity which is to be found within its pages. Long after new drugs have found their proper place, imaging becomes commonplace in paediatric epilepsy and the chromosomal and mitochondrial genetics of epilepsy will have been sorted out, one will still be turning to this book for its humanism, its descriptions and the very strong impression that this book gives of a link between the past and the future. This is certainly one of the books that has stood the test of time and has helped me in my own work: I salute it.

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Epilepsy can start at any age including childhood. If your child develops epilepsy you may have questions or concerns. What is epilepsy? Some children develop epilepsy as a result of their brain being injured in some way. This could be due to a severe head injury, difficulties at birth, or an infection which affects the brain such as meningitis. Epilepsy with a known structural cause like this is sometimes called symptomatic epilepsy. Some researchers now believe that the chance of developing epilepsy is probably always genetic to some extent, in that anyone who starts having seizures has always had some level of genetic tendency to do so. This level can range from high to low and anywhere in between. Less common causes of childhood epilepsy include brain tumors and degenerative disorders. It must be noted that there is a significant difference between something that causes fits, such as a high fever, and something that causes fits, due to severe head injury. A fit or a seizure may occur within 1 or 2 days of an immunization, especially if it is followed by a fever.

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Epilepsy accounts for up to 2% of all diseases in childhood. In the US, statistically over 400,000 children live with this condition. A seizure of epilepsy can begin in any child 1. Childhood and Juvenile Absence Epilepsies. This epilepsy syndrome has an onset age that is between four to ten years and is characterised by sudden stillness and staring spells. Also called as "petit mal" epilepsy, it is usually outgrown. This difficult to treat epilepsy has an onset age of one to eight years. The seizures are known to be resistant to epileptic drugs and often require alternate treatments and surgery. These are generalised seizures that are characterised by a combination of different seizures and often cause development delays and behavioural issues. Benign focal (partial) epilepsies of childhood are electroclinical syndromes of unknown or genetic cause that occur in developmentally and neurologically normal children and have a benign course, remitting prior to adulthood. These epilepsy syndromes are distinguished from symptomatic focal epilepsy, which refers to epilepsy that results from brain injury or other structural brain disease. Thus, the benign focal epilepsies of childhood can be viewed as a spectrum of conditions with "functional" or "nonlesional" focal epileptogenicity, each characterized by location and seiz