

the variation in urinary PEA levels among individual patients is large.

The above report confirms previous findings of decreased urinary levels of PEA in children with ADHD (Zametkin AJ et al. 1984; Baker GB et al. 1991). An abnormality in the absorption or transportation of phenylalanine is suggested as one explanation for the decreased PEA excretion, but symptoms of ADHD are not improved by treatment with phenylalanine (Zametkin AJ et al. 1987). Monoamines including HVA and 5-HIAA have been linked to ADHD in some studies, but the present report does not support an association. Further investigations are warranted.

## **TRIAL OF DIVALPROEX FOR BIPOLAR DISORDER**

The safety and effectiveness of divalproex sodium (Depakote®) in the treatment of 40 children and adolescents, aged 7 to 19 years, with a primary diagnosis of bipolar disorder were evaluated by open-label study (2-8 weeks) at the University of Texas, Galveston; University of Pennsylvania, Philadelphia; SUNY Stony Brook, NY; Massachusetts General Hospital, Boston; and University of Texas, San Antonio. Six subjects (15%) had comorbid ADHD that required stimulant therapy in addition, and 23 (58%) had a comorbid psychiatric diagnosis that was treated with concurrent medications, including lithium, haloperidol, or lorazepam. A greater than 50% improvement was obtained in 22 subjects (61%) as measured by the Mania Rating Scale (MRS). Mean scores of all efficacy measures showed significant improvements ( $p < .001$ ) from baseline, including the MRS, Manic Syndrome Scale, Behavior and Ideation Scale, Psychiatric Rating Scale, and Hamilton Rating Scale. At the completion of the study, the mean divalproex dose was 17.5 mg/kg per day, and the mean serum valproate level was 83.4 mcg/ml. Twenty seven subjects (68%) reported one or more adverse events, the most common including headache (7), nausea (7), vomiting (6), diarrhea (4), and somnolence (4). Twenty four subjects discontinued treatment because of lack of efficacy (6), drug intolerance (6), noncompliance (6), and other reasons (6). None required drug withdrawal because of abnormal laboratory values. A planned double-blind, placebo-controlled study to follow the open-label period was abandoned because of insufficient number of patients. (Wagner KD, Weller EB, Carlson GA et al. An open-label trial of divalproex in children and adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry October 2002;41:1224-1230). (Reprints: Dr Wagner, Department of Psychiatry and Behavioral Sciences, University of Texas Medical Branch, 301 University Blvd, Galveston, TX 77555).

**COMMENT.** The authors conclude that the results provide support for the safety and effectiveness of divalproex in the treatment of bipolar disorder in children and adolescents. However, failure to complete the study period in more than 50% of patients is not a favorable recommendation.

The comorbidity of ADHD in children with bipolar disorder is a frequent occurrence, with estimates up to 94% (Wozniak et al. 1995). Treatment often requires a combination of stimulant medications and antidepressants.

## **NEUROMUSCULAR DISORDERS**

### **TICK PARALYSIS**

Six children aged 3.3 to 5.5 years (5 girls and 1 boy), of 26 admitted with acute muscle weakness to the University of Mississippi Medical Center, Jackson, over a 5 year period (1992-97), were diagnosed with tick paralysis. The initial