

and Department of Public Health, Universite Paris XII, Creteil, France; and centers in Boston, US; Milan, Italy; Freiburg, Germany; Porto, Portugal; and Toronto, Canada. In 245 patients hospitalized for treatment, the relative risks with various drugs were as follows: carbamazepine 90, phenytoin 53, phenobarbital 45, valproic acid 25, compared to 172 for sulfonamide antibiotics, 6.7 for aminopenicillins, and 54 for corticosteroids. For many other drugs in common use, including contraceptive pills, benzodiazepines, and phenothiazines, the risk of serious skin reactions was not increased. (Roujeau JC et al. Medication use and the risk of Stevens-Johnson syndrome or toxic epidermal necrolysis. N Engl J Med Dec 14, 1995;333:1600-7). (Reprints: Dr Roujeau, Service de Dermatologie, Hopital H Mondor, 94010 Creteil, France).

COMMENT. The incidence of toxic epidermal necrolysis is estimated at 0.4 to 1.2 cases per million person-years and of Stevens-Johnson syndrome, at 1 to 6 cases per million person-years. None of the above drugs caused an excess risk greater than 5 cases per million users per week. The excess risks ranged from a low of 0.2 per million for aminopenicillins to a high of 4.5 per million for sulphonamides. For the anticonvulsants, excess risks of these skin reactions ranged from a low of 0.7 for valproic acid to a high of 2.5 for carbamazepine. Despite the relatively low incidence, these skin syndromes may kill or lead to prolonged hospitalization and extreme discomfort. Patients introduced to any of the above anticonvulsants should be warned of the dangers of skin rash, especially within the first two weeks of treatment, and instructed to discontinue medication and report to a physician immediately at the first sign of reaction. Carbamazepine appears to be the worst offender, and valproic acid is not immune. Corticosteroids, a controversial treatment for Stevens-Johnson syndrome, carries a surprisingly increased risk of inducing the disorder. Benzodiazepines, having no excess risk of Stevens-Johnson syndrome, are the obvious agents to substitute when other anticonvulsants are discontinued due to these severe skin reactions.

Carbamazepine-induced skin rash is reviewed in Progress in Pediatric Neurology II, 1994, PNB Publishers, pp 107-109. A personal communication from Ciba-Geigy recorded 30 cases of carbamazepine-induced Stevens-Johnson syndrome, 8 erythema multiforme, and 5 toxic epidermal necrolysis (Lyell's syndrome) reported to the company in an eight year period, 1982-89. The above international study found 13 cases related to carbamazepine, and accounting for 5% of the total drug-induced severe cutaneous reactions, during a four year period, 1989-93.

MOVEMENT DISORDERS

COMORBID TOURETTE'S AND BIPOLAR DISORDERS

Of 205 patients with Tourette's disorder in the North Dakota Longitudinal Tourette Syndrome Surveillance Project, 15 had comorbid bipolar disorder. The ratio of males to females was 5.2:1. The estimated risk of developing bipolar disorder among the study group of children and adolescents with Tourette's disorder was more than four times higher than the level expected by chance, significant at the 0.05 level. Males were at greater risk than females, and adults had comorbid developmental disorders as well. Shared common neural pathways, especially basal ganglia structures, and genetic factors may explain the comorbidity. (Kereshian J et al. Comorbid Tourette's disorder and bipolar

disorder: an etiologic perspective. Am J Psychiatry November 1995;152:1646-1651). (Reprints: Mr Larry Burd, Medical Center Rehabilitation Hospital, 1300 South Columbia Rd, Grand Forks, ND 58202).

COMMENT. The authors have previously published case-reports of patients with comorbid Tourette's disorder and bipolar disorder, some with early histories of attention deficit hyperactivity disorder. The frequency and intensity of motor and vocal tics were positively correlated with manic symptoms and inversely with depressive symptoms. Noradrenergic, dopaminergic, and serotonergic mechanisms have been invoked in all three disorders.

ATTENTION DEFICIT AND BEHAVIOR DISORDERS

ATTITUDES OF PEDIATRICIANS TO ADHD DIAGNOSIS

Pediatricians' perceptions of ADD and ADHD diagnosis, child and family communication concerning diagnosis and treatment, and treatment issues were examined in a cross-sectional survey involving 380 members of the American Academy of Pediatrics and conducted by the Department of Psychology, University of California-Riverside and Loma Linda University Medical Center, CA. Two thirds of respondents enjoyed treating children with ADD/ADHD, but 40% complained of the time involved, and 87% obtained inadequate insurance compensation. Only 18% were likely to refer patients with ADHD to other specialists, including psychiatrists, psychologists, social workers, educators, or neurologists. Most found schools cooperative in providing information of help in diagnosis and in administering medications. The relative frequencies of medications prescribed were as follows: methylphenidate 98%, slow-release methylphenidate 80%, pemoline (Cylert) 51%, amphetamines 27%, clonidine 6%, and tricyclics 4%. Medications were given daily (57%), weekdays only (44%), and during school year only (60%). Side effects reported by parents included: insomnia (18%), change in mood or affect (15%), headaches (10%). Parental views of ADHD included: diet related (20%), due to poor discipline (10%), poor parenting (12%), classroom inadequacies (21%), boredom at school (13%), medicine is addicting (49%), medicine makes child zombielike (19%), and drugs inhibit growth (8%). (Kwasman A et al. Pediatricians' knowledge and attitudes concerning diagnosis and treatment of attention deficit and hyperactivity disorders. A national survey approach. Arch Pediatr Adolesc Med Nov 1995;149:1211-1216). (Reprints: Dr Tinsley, Department of Psychology, University of California, Riverside, CA 92521).

COMMENT. The authors recommend further studies to elucidate relationships among pediatrician, parent, and patient beliefs about ADD/ADHD diagnosis and treatment. The low pediatrician referral rate to other specialists in the field might be explained in part by 50% of parents having consulted a psychologist before requesting medical treatment. The lack of educational testing in 50% of patients before receiving medication was disturbing, since many have associated learning disabilities. The pediatricians' attitudes and knowledge of comorbid psychiatric and neurologic disorders and their management would have been of interest, since only 18% referred patients to other specialists.