

and epilepsy whose seizures are controlled with antiepileptic drugs. Pemoline (Cylert) is generally considered to have less tendency to lower seizure threshold than MPH. Some recommend an EEG in all ADHD patients considered for stimulant medications; those with a history of seizures and/or epileptiform discharges in the EEG should receive concomitant AED therapy. Children with ADHD have a 7% incidence of epileptiform EEGs. (Ped Neur Briefs Oct 1989; Progress in Pediatric Neurology 1, 1991, p 190).

COGNITIVE DEFICITS AND DEPRESSIVE SYMPTOMS

The efficacy of a new program (The Penn Prevention Program) to prevent depressive symptoms and alleviate associated deficits in academic achievement, peer relations, self-esteem, and behavior is reported in 69 'at risk' 10-13 year-old children evaluated in the Department of Psychology, University of Pennsylvania, Philadelphia, PA. Using cognitive-behavioral techniques proactively to teach coping strategies, children at risk of developing depression, based on level of symptoms and perception of parental conflict, showed significant reductions in depressive symptoms and improved classroom behavior. Benefits were sustained at 6-month follow-up, especially in children with higher risk factors, as compared to control groups. (Jaycox LH et al. Prevention of depressive symptoms in school children. Behav Res Ther Nov 1994;32:801-816). (Respond: Dr Lisa H Jaycox, Department of Psychology, University of Pennsylvania, 3815 Walnut Street, Philadelphia, PA 19104).

COMMENT. The authors hypothesize that children at risk for depression use skills learned in the Penn Prevention Program to deal with conflict and avoid depressive symptoms precipitated by interpersonal problems. This type of program could be important in children with ADHD and learning problems who are at increased risk of developing depressive symptoms associated with poor self esteem and academic failure.

HEAD INJURY

POST-HEAD INJURY FUNCTIONAL DEFICITS

The functional outcome in 95 children (aged 5 to 15) at 1 year after hospitalization for head injury was evaluated at the Johns Hopkins University, School of Hygiene and Public Health, Baltimore, MD. More than half of all injuries were motor vehicle related: 21% pedestrians, 18% passengers, and 17% bicycles. Lower extremity injuries were sustained in 20. Severity of head injury was determined using the Abbreviated Injury Scale (AIS 2-5) and the Glasgow Coma Scale (GCS 3-15). GCS were highly correlated with AIS severity. Chronic health problems pre-dating the injury were reported in 23%; these were minor in 15%, and major (mental retardation, seizures, lead poisoning) in 8%. After controlling for head injury severity, poorer outcomes were associated with poverty, preinjury chronic health problems, and lower extremity injuries. At 1 year follow-up, 55% had one or more health problems: headaches in 32%, limb or peripheral nerve disorders (13%), weakness or ataxia (7%), and vision, hearing, or speech disorder (6%). The presence of functional limitations in physical activity (31%) or self-care mobility (19%) was associated especially with severe head injuries (AIS 5), but those with AIS 2-4 were not spared at least one limitation. Hyperactive behavior was directly correlated with head injury severity, and head-injured children had a greater