INFECTIOUS DISORDERS

LYME NEUROBORRELIOSIS

The clinical and epidemiological features of 187 consecutive patients with neuroborreliosis recognized in Denmark over a 6-year period, 1985-1990, are reported from the Department of Infection-Immunology, Statens Seruminstitut, Copenhagen, Denmark. The most common manifestation was a painful lymphocytic meningoradiculitis (Bannwarth's syndrome), and CNS involvement in early cases was rare. Neuroborreliosis in children showed a different course compared to adults. Headache was considerably more frequent (70%) compared to adults (35%) whereas radicular pain was significantly less common and less severe in children. Clinical signs of meningitis were reported in 38% of children and in only 3% of adults. Facial palsy in 26 of 40 childhood cases was bilateral in only 3, and was unassociated with pain, fever or neck stiffness. The diagnosis is based on inflammatory CSF changes and B. burgdorferi specific intrathecal antibody production (Hansen K, Lebech AM. The clinical and epidemiological profile of lyme neuroborreliosis in Denmark 1985-1990. Brain April 1992; 115:399-423). (Correspondence: Dr. Klaus Hansen, Borrelia Laboratory, Department of Infection-Immunology, Statens Seruminstitut, Artillerivej 5, DK-2300 Copenhagen S, Denmark.)

> **COMMENT.** Neuroborreliosis in children is often less dramatic than in adults and may be insidious with fluctuating headache, loss of appetite, weight loss, slight meningeal signs but rare focal neurologic signs. Similar findings to the experience in Denmark are reported from the United States. (Belman AL. Neurologic complications of Lyme disease in children. Experience in an endemic area and review of the literature. Int Pediatr 1992; 7:136-143.)

LEARNING AND BEHAVIOR DISORDERS

FOOD-INDUCED HYPERKINESIS

The results of a controlled trial of hyposensitization with intradermal EPD (beta-glucuronidase and food antigens) in 40 children with the hyperkinetic syndrome are reported from the Universitatskinderklinik, Lindwurmstrasse, Munchen, Germany and The Allergy Unit, London, UK. The study was in 3 phases: the first consisted of the oligoantigenic diet; children who responded to the diet entered the reintroduction of foods, phase II; and those with food-induced hyperkinetic syndrome entered phase III, a double-blind, placebo-controlled trial of EPD, 3 intradermal doses at 2-monthly intervals. Of 20 patients who received the hyposensitization active treatment, 16 became tolerant toward provoking foods, compared with 4 of 20 who received placebo ($p < 0.001$). The authors conclude that EPD permits children with food-induced hyperkinetic syndrome to eat foods that had previously been identified as responsible for their symptoms (especially chocolate, colorings, cow milk, egg, citrus, wheat, nuts and cheese). Food allergy is considered a possible mechanism of the hyperkinetic syndrome. (Egger J et al. Controlled trial of hyposensitization in children with food-