adults is uncommon in children, but pelvic imaging (MRI) is important since surgical removal of a tumor is followed by rapid recovery. See **Ped Neur Briefs** Jan 2010;24:1-2, for reports of NMDAR and dyskinetic encephalitis lethargica (Dale RC et al. **Ann Neurol** 2009;66:704-709). In the above case report, pelvic MRI was negative, but the authors recommend close surveillance. They credit the favorable outcome to early initiation of immunosuppressant therapy.

MOVEMENT DISORDERS

OPSOCLONUS-MYOCLONUS FOLLOWING *MYCOPLASMA PNEUMONIAE* INFECTION

Three adolescent cases of opsoclonus-myoclonus (OMS) that followed infection with mycoplasma pneumoniae are reported from University Hospital, Bern, Switzerland. Case 1. A 10-year-old girl presented with a 3-day history of uncontrolled eye movements and whole body tremor, followed by cerebellar ataxia. Two weeks previously she had pneumonia due to *M pneumoniae* (nasopharyngeal PCR positive, and IgM antibodies elevated). MRI brain showed no signs of inflammation, and tests for a paraneoplastic etiology were negative. Following methylprednisolone, symptoms slowly improved. Steroids were weaned over 10 months, and at 30-month follow-up, no relapse had occurred. Two further cases, both aged 14 years, developed OMS 2 to 4 weeks following *M pneumoniae* respiratory infection. Neuroblastoma was ruled out. Recovery from OMS occurred after 2 to 4 weeks of methylprednisolone therapy. (Huber BM, Strozzi S, Steinlin M, Aebi C, Fluri S. *Mycoplasma pneumoniae* associated opsoclonus-myoclonus syndrome in three cases. **Eur J Pediatr** April 2010;169:441-445). (Respond: Dr S Fluri, Department of Pediatrics, University Hospital, Inselspital, CH-3010 Bern, Switzerland. E-mail: simon.fluri@insel.ch).

COMMENT. One previous case of OMS following *M pneumoniae* infection is cited in a 4-year-old girl (Chemli J et al. **Arch Pediatr** 2007;14:1003-1006). Among pediatric cases, OMS generally presents between 6 months and 3 years of age, and neuroblastoma is present in 50% cases. In the above parainfectious childhood cases of OMS, response to steroid therapy was rapid and generally complete, and the long-term outcome was favorable. Neurological complications of *M pneumoniae* include meningoencephalitis, acute disseminated encephalomyelitis, acute transverse myelitis, cerebellitis, abducens nerve and Bell's palsies, and Guillain Barre syndrome. (Yis U et al. **Eur J Pediatr** 2008;167(9):973-978).

SEIZURE DISORDERS

ANTIHISTAMINES AND FEBRILE SEIZURE SUSCEPTIBILITY

Charts of children with febrile seizures admitted to the Hospital of Shiga University of Medical Sciences, Otsu, Japan, 2006-2007, were reviewed retrospectively. Clinical characteristics of 23 patients who received antihistamines were compared with

26 with no antihistamines. No significant difference was observed in sex ratio, age, family history of febrile seizures or epilepsy, cause of fever, and proportion of simple and complex febrile seizures between antihistamine and non-antihistamine groups. In the antihistamine group, time from fever detection to seizure onset (simple and complex separately or together) was significantly shorter ($P<0.001$), and seizure duration was significantly longer ($P<0.05$). Seizure types and EEG abnormalities were similar in the two groups. Hypothalamic neuronal histamine depletion induced by antihistamines may lower febrile seizure threshold and increase seizure susceptibility.(Takano T, Sakaue Y, Sokoda T, et al. Seizure susceptibility due to antihistamines in febrile seizures. **Pediatr Neurol** April 2010;42:277-279). (Respond: Dr Takano, Dept Pediatrics, Shiga University of Medical Science, Otsu, 520-2192, Japan. E-mail: tmyktkn@belle.shiga-med.ac.jp).

COMMENT. This clinical study supports the significance of many prior laboratory experiments that demonstrate an increase in seizure susceptibility following antihistamine administration. The febrile seizure threshold temperature was lowered and severity of experimental seizures exacerbated in animals following diphenhydramine administration (Millichap JG et al. Neurology 1960;10:575). West syndrome has been associated with antihistamines in Japan (Yasuhara A et al, 1998; Yamashita Y et al, 2004). Patients with seizures should be cautioned to avoid antihistamine medications when possible.

MELATONIN AND INTRACTABLE EPILEPSY

The relation of serum melatonin levels to sleep patterns and effects on seizure severity were evaluated in 23 children with intractable epilepsy compared to 14 with controlled seizures, in a study at Ain Shams University, Cairo, Egypt. The children with intractable epilepsy had significantly higher scores in sleep walking, teeth grinding, and sleep apneas, compared to those with controlled epilepsy. Diurnal/nocturnal melatonin levels were not significantly different in patients with controlled seizures (10.79/28.7 pg/ml) and uncontrolled seizures (21.9/15.2 pg/ml). Diurnal levels in patients with controlled seizures were significantly lower than levels in a healthy control group (10.79 vs 25.95). Patients with intractable epilepsy received 1.5 mg regular release melatonin 30 min before bedtime for 3 months, in addition to their anticonvulsants that were not changed. An initial dose of 3 mg melatonin was changed to 1.5 mg because 2 patients had increased seizures. With oral melatonin, sleep disorders, including enuresis, sleep walking, sleep apnea, and Epworth sleepiness scores improved in patients with intractable epilepsy. Reduction in seizure severity was significant, but reduction in seizure frequency in 20 (87%) patients was not significant. Seizures increased in frequency in 3 (13%). EEGs became normal in 3 patients. Two patients had headache, skin rash, and abdominal pain. (Elkhayat HA, Hassanein SM, Tomoum HY, et al. Melatonin and sleep-related problems in children with intractable epilepsy. **Pediatr Neurol** April 2010;42:249-254). (Respond: Dr Tomoum, 10 El-Nagah Street, El-Nozha, Cairo 11361, Egypt. E-mail: tomoumh@yahoo.com).