neuroleptic malignant syndrome, and this presentation of carbon monoxide poisoning led us to treat the patient with dantrolene, with good effect. Thermogenesis was probably due to skeletal muscle rigidity, and the relaxant action of dantrolene produced a fall in temperature as a secondary benefit.

Our patient may have recovered spontaneously, but the responses to dantrolene merit notice. Further investigation is needed to see whether dantrolene is effective in treating severe cases of carbon monoxide poisoning. Moreover, its use in other hypermetabolic states could be beneficial.


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Photosensitive epilepsy in children who set fires

The flickering light of television is recognised as epileptogenic. Some children with photosensitive epilepsy find viewing television compulsively attractive and even induce seizures by viewing it (C D Bonnie, Consultant psychiatrist, epilepsy, Salisbury, 1987). Flames may be a self-induced stimulus in those children with photosensitive epilepsy who repeatedly set light to things (fire setting).

Case reports

CASE 1

A man aged 31 had his first attack of epilepsy at the age of 7, when he saw “hundreds of tiny silver dots, then blackness.” Minutes later his sight returned. He had innumerable similar attacks for eight years. As his vision cleared he was overayed by anger and violence commonly followed: he punched bystanders, broke windows, and burned sheds and hedgerows. Recognising the sequence, he tried to limit the damage, running off alone whenever he saw the silver dots.

His behaviour antagonised his parents. He was seen in child guidance clinics, put on probation, taken into care, placed in children’s homes, and sent to approved schools, but his disruptive behaviour continued, often after viewing television. At age 13 his epilepsy was diagnosed. Electrocencephalography without photosensitive stimulation showed diffuse abnormalities, ataxia and sharp and slow components that were maximal in the posterior left temporal region. Although prescribed phenytoin, he palmed the tablets. His attacks stopped without treatment at age 15, and electrocencphalographs were subsequently normal.

CASE 2

From babyhood the 6 year old daughter of the man in case 1 had thrown paper on to fires and watched it burn. She set fire to her toys, singed her hair’s fur, burned matches through the letterbox, and fused an electric circuit with burning papers. She watched television from a distance of 50 cm with maximum colour and contrast. Her mother noticed repeated short episodes, while she was watching television when she suddenly stared at the wall, white faced and withdrawn. Tears or pranks followed; once she set fire to the sofa. Epilepsy was suspected, and while awaiting neurological investigation she stole a cigarette lighter. Her father, fearing a fire, called her, and she was admitted to hospital. Compulsory care proceedings were started. On transfer to another hospital an electroencephalogram showed typical photovoltausant responses during photic stimulation at flash rates above 10 cycles second, particularly with red and orange light; the recording was otherwise normal. She returned home and complied with instructions to stay three metres from the television screen. Her behaviour was exemplary. Three months later a 24 hour ambulatory electroencephalogram showed that abnormalities occurred immediately when she viewed television from her former position.

After six months of normal behaviour her parents reported renewed moodiness, then discovered caches of spent matches. Meanwhile her teachers, misled by her epileptic fits, inflated for absorption, suspected parental cruelty. Electroencephalography showed sensitivity to fluorescent light, to which she was exposed at school, and to patterns. She was admitted to hospital for drug treatment under electroencephalographic control. Photic spikes lessened with phenytoin, returned with carbamazepine, then disappeared with sodium valproate 200 mg twice daily. She continued to take this drug, and her behaviour was normal during the next six months.

Comment

Fire setting and photogenic epilepsy might coexist by chance but were closely linked in these two cases. The aggressive conduct of the patient in case 1 followed his seizures, and he continued to set fires until he outgrew his epilepsy. His daughter (case 2) behaved normally after avoiding the photic stimulus of close viewing of the television. She began to set fires again in response to photic stimulation by fluorescent lights. Both her fire setting and electroencephalographic abnormalities resolved on treatment with sodium valproate.

Fire setting inevitably causes family disturbances, and blaming the child or the family may lead to inappropriate attempts at containment instead of treatment. Suggestivity to television as a cause of epilepsy is easily missed because the family watches the screen, not each other. Flames lit during preictal compulsion or postictal confusion may kindle further epilepsy.

Those who set fires, particularly younger, solitary children, should undergo electroencephalography.

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An offer of rheumatology training: failure to influence clinic referrals

It has been suggested that teaching of small groups of general practitioners by consultants in the general practitioners’ surgeries may be a more useful approach than lectures to large audiences in hospitals.1 Such teaching can influence the behaviour of general practitioners volunteering for educational sessions,2 but education does not necessarily decrease the demand for specialist opinions.3 This study reports the responses of general practitioners referring patients with soft tissue lesions of the shoulder and elbow when they were offered individual clinical tutorials by a consultant.

Patients, methods, and results

From 1 August 1984 until 31 July 1987 every general practitioner who referred a patient with an uncomplicated soft tissue lesion of the shoulder or elbow to a rheumatology clinic was sent an offer of individual teaching by a consultant with the relevant patient’s clinic letter. This offer suggested that the general practitioner may have another patients with shoulder or elbow lesions he or she should contact the consultant, who would come to the surgery and, with the general practitioner, examine, diagnose, and, where appropriate, inject the patient’s soft tissue lesion. Further letters were sent to the general practitioners after each subsequent referral. These educational offers had no implications with respect to section 63 or domiciliary visit payment. In all 120 offers were made (19 in relation to elbow and 101 in relation to shoulder lesions) to a total of 41 principals and four trainees. Twenty doctors received two or more offers, and six sessions were arranged, with nine general practitioners receiving teaching.

A lunchtime meeting entitled “shoulder pain—the GP’s role,” accounting for a half of a section 63 session, was organised twice and a half years after the start of the study at this hospital, and all general practitioners in Leeds were invited to attend. The potential effects of the educational exercise on clinic load were examined by observing how many referrals in the last six months of the study might have been avoided if general practitioners who had received two or more educational offers had responded to them and managed the patient themselves.