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Reflex anoxic seizures

Sir,

I am grateful to Dr Bower[1] for drawing attention to reflex anoxic seizures but I take strong issue with his preference for 'pallid syncope'. Of course there are many children who get pale and floppy and unresponsive, who may have vasovagal syncope, and for whom the term pallid syncope is perfectly acceptable. But what I mean by a reflex anoxic seizure is 'a particular type of fit which is neither epileptic nor due to breath-holding, but rather results from brief stopping of the heart through excess activity in the vagus nerve'. A typical example in the form of venepuncture fits has recently been published,[2] but it is important to recognise that the patients do not always go pale, nor do observers always notice the pallor. I believe I have seen more anoxic seizures after ocular compression than anyone else (over 300) and can assert that pallor is not constant, particularly is it not observed in children who are not reported as pale in the natural attacks.

An anoxic seizure is very much a seizure, as Gastaut has well described. It may be violent and dramatic.[3] It is not sufficient to call such an event convulsive syncope for there is yet another type of seizure which must be distinguished, that is the anoxic-epileptic seizure[4] in which the syncope is concluded by a train of spike and wave with clonic component. If anoxic seizures are not specifically recognised, they will be called epileptic, even, I suspect, in 1985.

Although I think precision in terminology is helpful in communication between doctors, different words may be more helpful with patients and parents. When I talk about reflex anoxic seizures I call them 'fainting fits and not epileptic fits'. I explain how the vagus makes the heart stop, but that it can only keep on telling the heart to slow down while it is getting enough blood so as soon as it does not the heart will speed up again and all will be well. I nowadays use ocular compression mainly as an aid to reassurance, and agree that in most cases a meticulous history will give the diagnosis. I do not think, however, that paediatricians need be worried about unsubstantiated dangers of the technique when it has to be used for reassurance, investigation, or research.

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Sir,

I enjoyed reading Dr Bower's annotation.[1] He makes the point that most paediatricians would be reluctant to use the oculo-cardiac reflex to show increased vagal reactivity in children with the pallid form of breath holding. May I suggest a technique that I have found very useful when given a suggestive story of this disorder by the parents. Explaining what the disorder is about to the parents, one asks that the child be laid down on the examination couch without preamble and that the upper garments be removed. The doctor stands ready with stethoscope and, at the first sign of a yell which is certain to occur in response to this sudden 'rough' handling, one is easily able to detect the dramatic slowing of the heart which will accompany the cry. The doctor should prepare himself to be moderately frightened by how dramatic the pallid breath holding attack can be.

I presented a paper on this topic at the Second Rhodesian Medical Congress in 1972 which I entitled 'Breath-holding—an Adams-Stokes attack'.

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Neck radiographs in croup syndrome

Sir,

In recent correspondence, Dr Porter[1] implied that in Aberdeen the initial routine investigation for possible epiglottitis was lateral neck radiographs rather than laryngoscopy. We feel it would be unfortunate if that comment and its potential influence on the practice of others went without reply.

Since the mid 1970s The Royal Aberdeen Children's Hospital has practised a policy of protective intubation in cases of severe croup, an experience we are currently reviewing. Our routine in children with severe stridor is not to attempt clinical or radiological diagnosis with their potentially dangerous delays, but to proceed to laryngoscopy by experienced staff (ear nose and throat and anaesthetic). There have been no problems to date with