are best disposed of via a WC pan in the isolation suite. Where this is not possible the beds and urinals should be bagged within the unit and passed through the exit hatch and taken to the bedpan or bottle washer. Bedpans and bottles should be sterilised by machines close to the washing unit. The only exceptions to the immediate use of the public drainage system for disposing of excreta from infected patients are the enteric fevers, smallpox, Lassa fever, Ebola fever, and Marburg disease. In such cases prolonged contact with a suitable concentration of phenolic disinfectant is essential before disposal.

Dead bodies of patients who have suffered from diagnosed or suspected smallpox, Lassa fever, Ebola fever, Marburg disease, or serum hepatitis should be dealt with by staff wearing gloves and impermeable protective clothing, and should be enclosed in a large plastic bag before being taken from the room in which the patient died.

Waste from susceptible patients does not usually need any special arrangements.

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Personal Therapeutics

Childhood epilepsy

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Although the following scheme for the drug treatment of childhood epilepsy expresses my own preferences, it has been arrived at over the years after much discussion with many colleagues who share an interest in the welfare of these children and after consideration of the written views of many others.

Recent years have seen the rise to popularity of some relatively new drugs such as carbamazepine and sodium valproate (the latter having been greeted by some as the greatest thing since Greta Garbo) and a consequent relegation of others such as phenobarbitone and primidone. Available evidence suggests that carbamazepine has an anticonvulsant potency equal to that of phenytoin or phenobarbitone and produces fewer undesirable effects.

Phenobarbitone and primidone are now used less often because of the well-known risk of behaviour disturbance and possible interference with learning in young children. For the prophylaxis of febrile convulsions phenobarbitone is the only drug about which a large volume of information is available and, even so, the evidence about its effectiveness is conflicting.

Phenytoin is an effective anticonvulsant drug that has been in use for a long time and still has many devotees, but its numerous side effects and the relatively small difference between subtherapeutic and toxic doses make it, in my opinion, inferior to carbamazepine.

Sodium valproate is undoubtedly a very effective drug and, so far, has shown remarkably little toxicity. Some would prefer it to phenytoin but I do not use it as a first-choice drug, preferring to keep it in reserve for the more resistant cases. Nausea and vomiting occasionally restrict its use.

Nowadays, no drug can be said to have had an adequate trial unless adequate serum concentrations have been achieved, and such measurements help to avoid an unwarranted rush into polynarmacy. There is no proof that in epilepsy two drugs are better than one. If it becomes necessary to use a second drug the first should be gradually withdrawn as soon as the epilepsy is controlled. Only exceptionally should it be necessary to use more than one drug in the long term. I offer the following as a practical guide.

Choice of drug

Drugs are listed in order of preference. Use only one drug if possible—controlled by estimating serum drug concentrations if necessary.

Major generalised seizures (grand mal)—carbamazepine or phenytoin,* sodium valproate, primidone, phenobarbitone, acetazolamide, or sulthiame.

*In adolescent girls particularly, carbamazepine might be preferred in view of the risk of gingival hyperplasia and hirsuties.
**Suggested drug dosages**

| Drug                  | Proprietary name | Presentation | Dose mg/kg/day | Average dose at age | Therapeutic serum concentration |
|-----------------------|------------------|--------------|----------------|---------------------|-------------------------------|
|                       |                  |              | 2 years        | 7 years             | Adult                         |
|                       |                  |              | 15 mg twice or thrice daily | 30 mg twice or thrice daily | 30-60 mg twice or thrice daily |
|                       |                  |              | 30 mg twice or thrice daily | 30 mg twice or thrice daily | 30-60 mg twice or thrice daily |
|                       |                  |              | 60 mg twice or thrice daily | 60 mg twice or thrice daily | 60-150 mg twice or thrice daily |
|                       |                  |              | 15-35 | 60-150 |
| Phenobarbitone*       | Promidal         | Tablets 30, 60, 200 mg | 3-10 | 100 mg twice or thrice daily | 1-200 mg twice or thrice daily |
| Methylphenobarbitone  | Dilantin USA     | Capsules 25, 50, 100 mg | 0-5 mg thrice daily | 0-10 mg thrice daily | 0-20 mg thrice daily |
| Prisidone            | Myoline          | Tablets 250 mg 1 5 ml | 10-30 | 125 mg twice or thrice daily | 25-500 mg twice or thrice daily |
| Phenobarbitone*       | Epanutin USA     | Capsules 25, 50, 100 mg | 5-7 | 50-150 mg twice or thrice daily | 100-150 mg twice or thrice daily |
| Carbamazepine         | Tegretol         | Tablets 200 mg 5 ml | 10-20 | 100 mg twice or thrice daily | 2-400 mg twice or thrice daily |
| Sodium valproate      | Epilim           | Tablets 200 mg 5 ml | 25-50 | 2-400 mg twice or thrice daily | 3-600 mg twice or thrice daily |
| Clonazepam            | Rivotril         | Tablets 0-5, 2-0 mg | 0-10 | 1-0 mg thrice daily | 2 mg thrice daily |
| Nitrazepam            | Mogadon          | Tablets 5 mg 1 5 ml | 0-5-7 | 5 mg thrice daily | 10 mg thrice daily |
| Sulthiame             | Ospolot          | Tablets 50, 200 mg 5 ml | 10-15 | 100 mg thrice daily | 200 mg thrice daily |
| Acetazolamide         | Diamox           | Tablets 250 mg 1 5 ml | 20-50 | 250 mg twice or thrice daily | 500 mg twice or thrice daily |
| Ethosuximide          | Zentroin Emside | Tablets 250 mg 1 5 ml | 15-50 | 125 mg twice or thrice daily | 250 mg thrice daily |

*About 20% of young children will develop a behaviour disturbance on phenobarbitone.

†Note that with phenytoin a small dosage increment may take the serum concentrations from the subtherapeutic to the toxic range. Changes of dose should therefore be cautious and preferably monitored with serum concentrations.

‡With liquid preparations, especially phenytoin, emphasise the importance of shaking the bottle to avoid uneven distribution of the drug.

†Always start with minimum dose and increase gradually.

**Minor motor epilepsy**—nitrazepam, clonazepam, sodium valproate, sodium valproate, sodium valproate, sodium valproate, sodium valproate, sodium valproate, sodium valproate, sodium valproate, sodium valproate.

**Typical absence (petit mal)**—ethosuximide, sodium valproate, ethosuximide, ethosuximide, ethosuximide, ethosuximide, ethosuximide, ethosuximide, ethosuximide, ethosuximide.

**Complex partial seizures** (temporal lobe epilepsy) and other focal seizures—carbamazepine, phenytoin, phenytoin, primidone, sodium valproate, sodium valproate, sodium valproate, sodium valproate, sodium valproate.

**Infantile spasms**—steroids, nitrazepam, clonazepam.

**Choice of dosage**

Presentations and dosage are given in the table. In schoolchildren it is almost always possible to avoid giving a dose during school hours.

**Status epilepticus**

Status epilepticus should be treated as follows:

1. Maintain respiration: oral airway; oxygen by face mask.
2. At home: intramuscular paraldehyde 0.15 ml/kg or 1 ml per year of age. (A plastic syringe may be used, provided the paraldehyde is drawn up immediately before injection.)
3. In hospital: always have laryngoscope and endotracheal tube ready.
   a. Diazepam, 0.3 mg/kg intravenously.
   b. Clonazepam, 0.02 mg/kg intravenously. (Can be repeated in 20–30 min if necessary.)
4. Phenytoin, into drip side arm, 15 mg/kg over 15 min, then 2.5 mg/kg every 12 hours (check not having phenytoin routinely).
5. Oral sodium valproate, 50 mg/kg/day via nasogastric tube.
6. (a) Combat brain oedema: mannitol 20% 7 ml/kg intravenously over 30 min; or dexamethasone intravenously 0.1 mg/kg immediately then 0.05 mg/kg every six hours.

**Further reading**

A Textbook of Epilepsy, ed J Laidlaw and A Richens. London and New York, Churchill Livingston, 1976.

**WORDS** When a new word is needed, a responsibility lies with the designer of the new coinage. There are instances where the design might have been done better. isotope (1912), from G isos, equal + topos, place, would have been better as homotope (G homos, same + topos) and so named because it occupies the same place in the Periodic Table of the elements. atopy (Coca, 1923) (G atopos, out of place, strange, odd; from a-, no + topos) was applied to a group of allergic diseases—for instance, eczema, asthma, and hay fever, some of which commonly occur in the same person or in a member of his family. Surely most diseases and syndromes, when first discovered or investigated, equally merit the term atopic on the basis of their being "strange." Furthermore, when a disease is well understood and no longer strange it is no longer atopic. In any case the term was pre-empted by Sir Thomas More (1551) in his invention of Utopia, no place, that is, an imaginary, non-existent place. While on the topic, topical application of a drug is well described as such because it is applied in the place where it is effective, rather than given systemically to be transported to the desired place by the blood stream. We used to say local (L hocus, place), and we still speak of local application and local anaesthetic, but that term stuck before it was generally agreed that three syllables are better than two. And what about topics for discussion and topic teaching? Starting from the title of a work by Aristotle, Ta Topha, Concerning Commonplaces, considerations common to many kinds of subjects, thence by a long, tortuous, and barely recognisable route to its present meaning.