Letters

Although had in this link meningioma and meningioma infiltrating bone. There demonstrated compression of the left cortex, which was shown histologically to be a meningothelial meningioma infiltrating bone. There were no features of a sarcoma.

The association between fibrous dysplasia and meningioma does not seem to be recognised and this may be the first report. The direct juxtaposition of the dysplastic bone and the tumour make it likely that the link is causal. Neither previous cranietomy nor acrylic prostheses are known to be associated with meningioma and the patient had never been treated with radiotherapy. Although bone histology was not available in this case, the radiological appearances, the normal serum biochemistry and the age of onset in late childhood make fibrous dysplasia the only reasonable diagnosis. The bony changes could not be explained on the basis of the known hyperostosis which is associated with meningiomas both because many cranial bones were involved radiologically which were distant from the tumour and secondly no meningioma was present at his original craniectomy 22 years previously.

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Matters arising

Seasonal variations in the incidence of photosensitivity

Sir: The phenomenon of seasonal variability in photosensitivity of epileptic patients, reported by Danesi in his article, is at variance with the findings from two other British centres and is not corroborated by our data from the Netherlands.

Since 1980 we have conducted a prospective study of photosensitivity and its clinical implications in 100 photosensitive patients (Kasteleijn-Nolst Trenité, thesis in preparation) and no such consistent seasonal variability has been found. Table 1 lists the number of newly identified photosensitive patients against the total number of new EEG referrals for EEG investigation of epilepsy per season. Apart from a slight autumnal excess in incidence of photosensitivity (p < 0.1, chi-square), there is no seasonal difference. Moreover, unlike Danesi, we quantified the degree of seizures by measurement of the photosensitivity range. From Danesi's model one might expect not only the prevalence but also the degree of photosensitivity to be greater during winter time, yet when our 100 patients are divided into two equal groups according to their photosensitivity ranges at the time of the first examination, no such seasonal effect is present (table 2).

Dr Danesi's hypothesis of increased photosensitivity during the winter season is thus not supported by the findings of three other centres. On the contrary, in our material a weak seasonal effect appears to result from patients presenting with visually-induced seizures during the summer who then attend for EEG investigation in the autumn. This issue is not of purely academic interest as Dr Danesi's hypothesis leads to the prediction that chronic exposure to high levels of ambient lighting may have adverse effects on people with photosensitive epilepsy.

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References


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Table 1 Relation between the incidence of newly identified photosensitive patients and the number of new EEG referrals per season

<table>
<thead>
<tr>
<th>Season</th>
<th>Newly identified photosensitive patients</th>
<th>Total number of new EEG referrals</th>
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<tbody>
<tr>
<td>Spring (Mar, Apr, May)</td>
<td>20</td>
<td>586</td>
</tr>
<tr>
<td>Summer (Jun, Jul, Aug)</td>
<td>20</td>
<td>492</td>
</tr>
<tr>
<td>Autumn (Sep, Oct, Nov)</td>
<td>37</td>
<td>609</td>
</tr>
<tr>
<td>Winter (Dec, Jan, Feb)</td>
<td>23</td>
<td>655</td>
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<tr>
<td>Total</td>
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Table 2 Relation between degree of photosensitivity and season in 100 photosensitive patients

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<th>Photosensitivity range</th>
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<th>Autumn</th>
<th>Winter</th>
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<td>9</td>
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<td>20</td>
<td>37</td>
<td>23</td>
<td>100</td>
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</tbody>
</table>

Total 100 2342