an excess incidence among doctors and nurses.

The sharply conflicting data from the two studies suggests that one may be biased. The lack of any excess of MS among spouses of MS patients indicates that MS is not (or is very rarely) a transmissible disease among adults. This observation, as well as our study, and the potential biases outlined above suggest that the incidence and mortality of MS among doctors and nurses is likely to be close to that in the general population.

RICHARD GRAY

Clinical Trial Service Unit and ICRF Cancer Studies Unit, Radcliffe Infirmary, Oxford, UK

1 Dean G, Gray R. Do nurses or doctors have an increased risk of developing multiple sclerosis? J Neurol Neurosurg Psychiatry 1990;53:899-902.

Matters arising

or significant amelioration of seizure manifestations, but none is seizure free.

The starting dose of vigabatrin was reduced after the first 10 patients because seven of these patients suffered neurotropic side effects, in two cases severe. There were no severe neurotropic side effects in patients who started with a dose of 1000 mg/day. All of our patients who showed a therapeutic response did so at a dose of 2000 mg/day or less, and there were no patients in whom increasing the dose beyond this produced any further responsive effects.

Our group of patients was different from that of Sander et al, in the type of epilepsy, and in being composed entirely of outpatients who may have less severe disease. We have found its therapeutic effect less good, but our experience of the neurotropic adverse effects associated with vigabatrin is similar, and we too have seen tolerance develop in a significant number of patients. A response rate of 23% in patients refractory to first line anticonvulsant agents is certainly worthwhile, but careful supervision is required in the early stages of therapy, and we agree with Sander et al that vigabatrin should be used with particular caution in those with a previous history of psychological problems.

ILONEKA KRUTSCHEMANN

RODERICK DUNCAN

Institute of Neurological Sciences, Southern General Hospital, Glasgow, UK


Evaluation of vigabatrin in refractory epilepsy

We were interested to read the report by Sander et al of their experience of vigabatrin in 128 patients with severe medically refractory epilepsy, and in particular their comments on neurotropic side effects. We began using vigabatrin at the beginning of 1990 and were struck by the high incidence of such side effects. We therefore recorded the effects of vigabatrin therapy in 30 sequential patients.

All the patients had localisation related seizures intractable to conventional medical therapy. The seizures were complex partial in 24, focal motor in five, and secondary generalised in one patient. Eleven patients had secondary generalised seizures in addition to focal seizures. The average age was 33.9 years with an average duration of seizure disorder of 17.8 years. The first 10 patients were started on a dose of 2000 mg/day, the rest on 1000 mg/day (see below). The maximum dose used was 4000 mg/day. The patients were started on vigabatrin between January and August 1990, and all are still being followed up. Side effects permitting, all had a minimum three month trial of therapy.

Of the 30 patients started on vigabatrin only seven remain on it. The drug was withdrawn in 10 patients because of lack of effect, in four patients who relapsed following an initially good response (all the relapses have occurred within three months of starting therapy), in two patients whose seizures appeared to become worse on vigabatrin, and in five patients because of neurotropic side effects. This type of side effect was most common in the group as a whole, and included drowsiness (five), irritability (three), anxiety (one), depression (two), emotional lability (two), confusion (one) and psychosis (one). Other side effects included weight gain (two patients) and headache (one patient).

The seven (23%) patients remaining on vigabatrin therapy have all had either a useful reduction (> 50%) in seizure frequency, and