symptoms and 5 rashes that have not developed systemic signs (therapy was suspended). Lamotrigine is a well established antiepileptic known to be responsible for hypersensitivity reactions manifested through skin reactions. These kinds of ADRs are potentially life threatening if not recognized on time. The objective was to analyze and identify risk factors in cases of severe skin rashes associated with lamotrigine therapy.

Participants, Materials/Methods: Review of collected ADRs from Agency's database by the keyword lamotrigine and evaluation of these reports.

Results: Review of three cases of severe skin rashes caused by lamotrigine.

Case 1: 16-year-old patient within few weeks of combined therapy with lamotrigine 75 mg and valproate 450 mg daily experienced febrile reaction, exfoliative rash, had difficulties swallowing, sore throat and generalized maculopapular rash. At the same time, Beta Hemolytic Streptococcus (BHS) was isolated and he received benzatin-fenoxymetil penicillin, antihistamines and corticosteroids but progression of symptoms continued. Lamotrigine was discontinued, patient recovered.

Case 2: 4-year-old infant started receiving 10 mg lamotrigine daily with valproate 45 mg and clonazepam 1 g as a standard therapy. Twenty days afterwards mononucleosis like symptoms, maculopapular rash, enlarged spleen and lymph nodes along with high fever (40°C) developed. Lamotrigin was discontinued and patient recovered within 3 days.

Case 3: 14-year-old female patient received valproate 750 mg. Within 43 days of receiving concomitant lamotrigine 25 mg daily she experienced vulval redness and itching, diarrhea and rash indicating systemic hypersensitivity reaction. Reaction ceased upon discontinuation of lamotrigine.

Conclusions: In the presented cases we identified the cause of the severe ADRs as a result of given risk factors: too high dose, pediatric patients, interaction with valproate, drug-induced rash not recognized due to BHS infection respectively. The severity of rash in the reviewed cases and development of more severe symptoms has usually been related to duration of exposure to lamotrigine and it is not possible to predict reliably which rashes will prove to be serious or life threatening. That is why lamotrigine should ordinarily be discontinued at first signs of rash, unless the rash is clearly not drug related.

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Epilepsy and partial agenesis of corpus callosum (case report)

Dubravka Šepić Grahovac, Antonija Ružić Baršić & Tanja Grahovac
Department of neurology, Faculty of Medicine, University of Rijeka, Šetalište 13, divizije 24, 51000 Rijeka, Croatia
E-mail: poliklinika.interneuron@ri.t-com.hr

Introduction/Objectives: Epilepsy may be caused by number of different ethyologies. Seizures of partial origin with or without secondary generalization mostly have an underlying structural lesion and it is very important to notice present focal neurological deficit. Congenital malformations of the brain linked to epileptic seizures are well described and manifested in variable clinical spectrum. The association between partial agenesis of corpus callosum (ACC) and epilepsy has not been described often. The impaired psychological functions and the diminished level of some cognitive functions in patients with epilepsy and ACC, especially memory are related.

Participants, Materials/Methods: We present 35 year old, left-handed male with late onset of epilepsy presenting with secondary generalized seizures. In past history is information of neonatal central apnea. Neuroradiological features (MRI) were performed to exclude etiological factor for first seizure in his 31 years.

Results: Brain MRI revealed the partial agenesis of corpus callosum.

General physical evaluation and neurological examination showed excavated feet with shortened triceps tendon and mild bilateral pyramidal lesions.

Our patient has lower cognitive status than average population and neuropsychological tests demonstrated mental retardation as result of organic cerebral dysfunction.

Epilepsy becomes easily controlled after treatment with lamotrigine 200 mg twice daily.

Conclusions: Late-onset epilepsy needs multidisciplinary approach because underlying precipitating factors are different and sometimes unexpected, as it has been shown in our patient.

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Aseptic meningitis, sensorineural hearing loss induced by simultaneous use of ibuprophen and ciprofloxacin

Sepčić Juraj[1], Materljan Eris[2], Šepić Grahovac Dubravka[3] & Jurjević Ante[3]
[1]*Postgraduate Study,* [2]*Department of Family Medicine,* [3]*Department of Neurology, School of Medicine, University of Rijeka, Braće Branchetta 20, 51000 Rijeka, Croatia*
E-mail: erismaterljan@net.hr

Introduction/Objectives: Aseptic meningitis (AM), with or without other drug-induced neurological disorders, has been the subject of several reviews.

Participants, Materials/Methods: We report clinically rare and serious adverse reactions that occurred after the co-administration of Ibuprofen and Ciprofloxain: completely reversible aseptic meningitis and irreversible bilateral sensorineural hearing loss, tinnitus, and vestibulopathy.

Results: Recurrent urinary inflammations treated with antibiotics, classic migraine, and allergy to trimethoprim-sulfamethoxazole and chromium were favourable predisposing factors for the adverse event in this patient. A close chronological relation between administration of drugs (especially Ibuprofen) and adverse reactions was noted. No evidence of infection and/or autoimmune disease was found.

Conclusions: The mechanism of these serious events may be explained as a hypersensitive reaction affecting the meninges and, partially, cochlea.

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Etiologic aspects of carotid transient ischemic attacks

L. Tuskan-Mohar, D. Bonifacic, M. Legac, A. Jurjevic & L. Bolf
Department of Neurology, Clinical Hospital Center Rijeka Cambierijeva 17, 51000 Rijeka, Croatia
E-mail: ltuskan@net.hr

Introduction/Objectives: Transient ischemic attack (TIA) is a medical emergency indicating unstable brain ischemia with high risk of imminent stroke and requires immediate assessment and treatment. The aim of this study is to analyze the possible etiological factors of carotid transient ischemic attacks.

Participants, Materials/Methods: For the purpose of this study we use the traditional definition of TIA based on symptom duration and not on the presence of brain infraction on the brain imaging. During the 1-year period 108 patients (69 men and 39 women) were analyzed in Department of Neurology Clinical Hospital Center Rijeka.

Results: Our results show a male predominance (male 64%, female 36%). The principal risk factors like arterial hypertension had 71%