Journal of Pediatric Neurology 3 (2005) 71–72
IOS Press

Editorial

The Kleine-Levin syndrome

Natan Gadoth*
Department of Neurology, Meir General Hospital, Kfar-Saba 44281, Israel

Received 22 July 2004
Accepted 23 July 2004

Why write an editorial on a rare and enigmatic disorder, which is difficult to diagnose, lacks a definite laboratory test and is hardly mentioned in the classical text books i.e., 18 sentences in Bradley's Neurology in Clinical Practice [1], and 15 words including the two stating the name of the syndrome in Menkes Textbook of Child Neurology [2].

The average practicing pediatric neurologist is entitled to meet at least once, an adolescent with a history of episodic hypersomnia. He will most probably consider a number of possibilities in the differential diagnosis which are nicely outlined in the review on The Kleine-Levin syndrome (KLS) in this issue [3], and might also raise the possibility of KLS.

However, when such a youngster presents for the first time, the diagnostic dilemma is much more difficult. In the majority of cases studies such as lumbar puncture, electroencephalography, brain imaging and urinary toxicology screen will be performed, a psychiatry consult will be obtained and the boy or girl will be admitted to the hospital. In many, a provisional diagnosis of "flu" or "encephalitis" will be reached and in some with non-specific electroencephalographic changes the diagnosis of epilepsy will be offered followed by recommendation for long-term anticonvulsant therapy, especially on a repeated event.

We have been encountered with patients in whom drug abuse was suspected with consequent legal implications. Rarely the hypersexual behavior may be interpreted as sexual insult when conducted in public. We have had several patients who were initially admitted to a psychiatric ward.

The difficulty of establishing the diagnosis is due to the fact that there are no objective diagnostic tests while there are some supportive laboratory data.

This is the major obstacle for clinical research on KLS as one cannot be absolutely sure that the patients he had or other have diagnosed for him are really affected with KLS. We have tried to ascertain the diagnosis of KLS from papers published between the years 1925–1998. There were 108 full length articles which we have critically reviewed describing 163 patients. When applying the International Classification of Sleep Disorders (ICSD) criteria for KLS, only 87 of those patients fulfilled those criteria [4].

The establishment of the diagnosis upon the first attack based on the clinical characteristics outlined in the present review is possible and rewarding. It enables the physician to tell the frightened, confused youngster and the alarmed parents that the disorder is benign, transient and with excellent prognosis.

We were able to convince our military authorities to draft such youngsters into the army and have them serve successfully through a demanding and quite tough military service, while let them "sleep it off" during an attack.

References

[1] S. Chokroverty, Sleep and fits, in: *Neurology in Clinical Practice*, W.G. Bradley, R. Daroff, G.M. Fenichel and J. Jankovic, eds, Philadelphia: Butterworth and Heinemann, 2004, p. 2028.

*Correspondence: Natan Gadoth, M.D., Department of Neurology, Meir General Hospital, Kfar-Saba 44281, Israel. Tel.: +972 9 7472828; Fax: +972 9 7471317; E-mail: gadoth@post.tau.ac.il.

[2] J.H. Menkes, *Textbook of Child Neurology*, Baltimore: Williams and Wilkins, 1995, p. 798.
[3] N.S. Gordon, The Kleine Levin Syndrome, *J Pediatr Neurol* **3** (2005) 73–76.
[4] N. Gadoth, A. Kesler, G. Vainstein, R. Peled and P. Lavie, Clinical and polysomnographic characteristics of 34 patients with Kleine-Levin syndrome, *J Sleep Res* **10** (2001), 337–341.