Sir,
We thank Dr Stephenson for his favourable opinion of our work and agree that the slow-flat-slow pattern is probably independent of age, although we did not study this formally. We think that the clinical expression of syncope in any age group depends on the speed and depth of cerebral hypoperfusion, and suspect that such expressions may differ between children and adults. Our study cannot prove whether the appearance of some symptoms depends on yet other factors. It is possible that the execution of some movements depends on body position: in our study the subjects’ heads rested on a pillow, which would have prevented the appearance of weak opisthotonus, but not a strong one.

Our hypothesis that myoclonic jerks require cortical activity was based on a statistical analysis of 69 cases in whom synchronized clinical and EEG data were analysed with a 1 s resolution. Our conclusion indeed contrasts with earlier observations stating that myoclonic jerks could occur during flat phases of the EEG. However, our experience has made us wary to establish the relative time of fleeting clinical and EEG phenomena without recourse to repeated analysis of well-synchronized video and EEG signals.

We are aware that syncope in children can evoke an epileptic seizure on rare occasions, but know of no reliable reports in adults, and have not seen epileptiform EEG abnormalities evoked by syncope in the present series.

As Dr Stephenson mentions, oral automatisms have been mentioned in at least two earlier reports; our quantification suggests that they are much more common than this limited number of reports would suggest. We assume that their subtle nature has caused most people to miss them, except for a few astute observers.

Finally, We thank Dr Stephenson for noting the typographical error in a reference.

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