

Diagnosis and Management of Epilepsy in Adults

A Quick Reference Guide

Derived from the National Clinical Guideline recommended for use in Scotland
by the Scottish Intercollegiate Guidelines Network (SIGN)

A **B** **C** refer to **grade of recommendation**

DIAGNOSIS AND REFERRAL

History of attacks

From the patient **C**

- ❖ frequency of attack
- ❖ circumstances and trigger factors
- ❖ symptoms before and during the attacks
- ❖ duration of symptoms
- ❖ symptoms following the attack
- ❖ injury, tongue biting and incontinence

From the witness **C**

- ❖ frequency of attack
- ❖ detailed description of observations before and during the attacks (*including level of responsiveness, motor phenomena, vocalisation, colour, breathing, pulse*)
- ❖ detailed description of behaviour following the attacks

Diagnostically relevant factors **C**

- ❖ age
- ❖ sex
- ❖ social history
- ❖ past medical history, *including head injury and febrile convulsions*
- ❖ past psychiatric history
- ❖ alcohol and drug use
- ❖ family history

Is it epilepsy?

Consider differential diagnosis **B**

- ❖ Vasovagal syncope and psychogenic non-epileptic attacks (pseudoseizures) need to be distinguished from epileptic seizures as they commonly present difficulties with diagnosis
- ❖ See Annex 2 for other disorders which may need to be considered

Referral **C**

- ❖ All patients with definite epilepsy or diagnostic uncertainty should be referred to specialist services *except in exceptional circumstances, e.g. elderly incapacitated patients with stroke*

GP may initiate drug therapy, preferably in discussion with hospital specialist, if there is likely to be a delay **C**

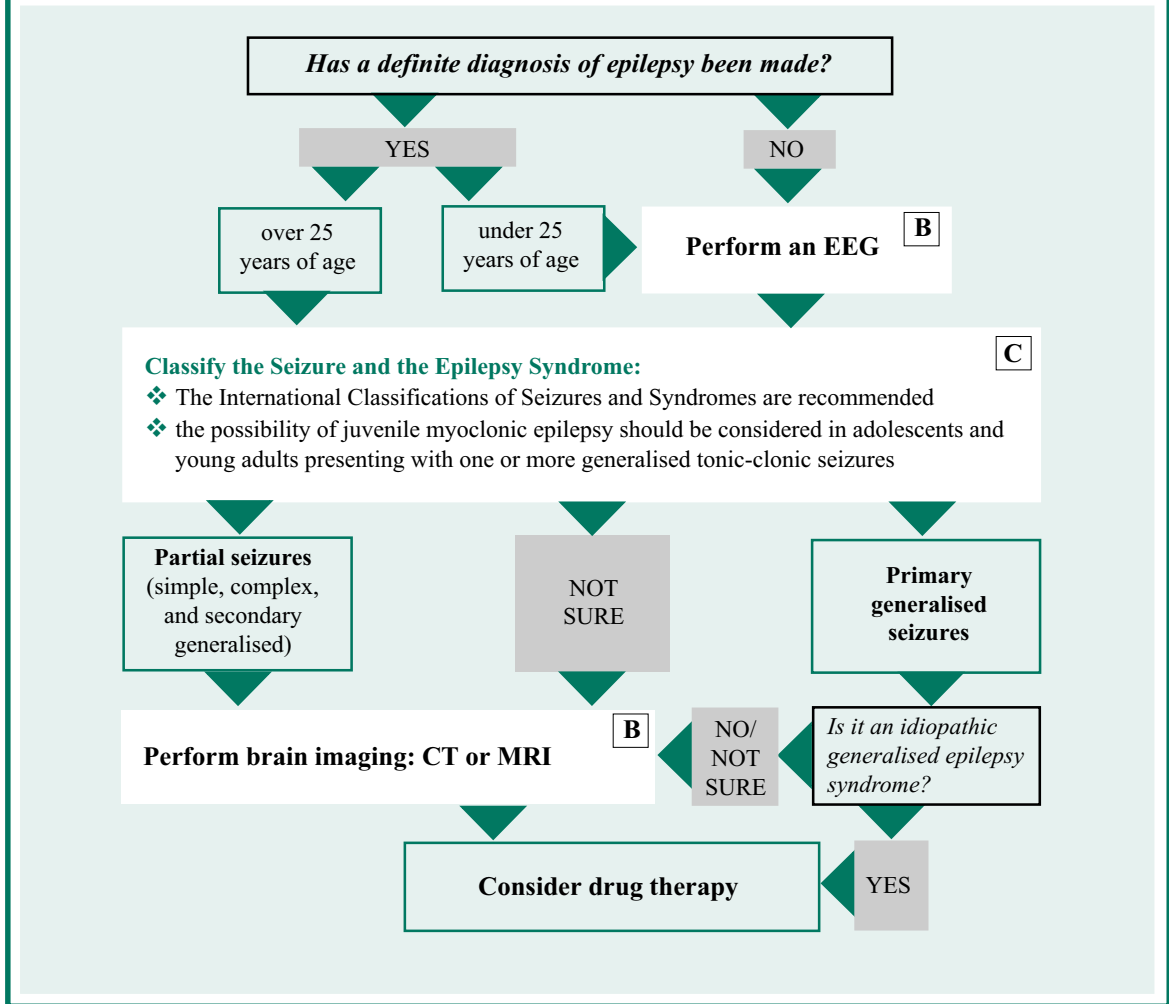
Some form of planned shared care is the preferred model of care for patients with epilepsy **C**

Additional copies of this Quick Reference Guide and the full guideline are available from

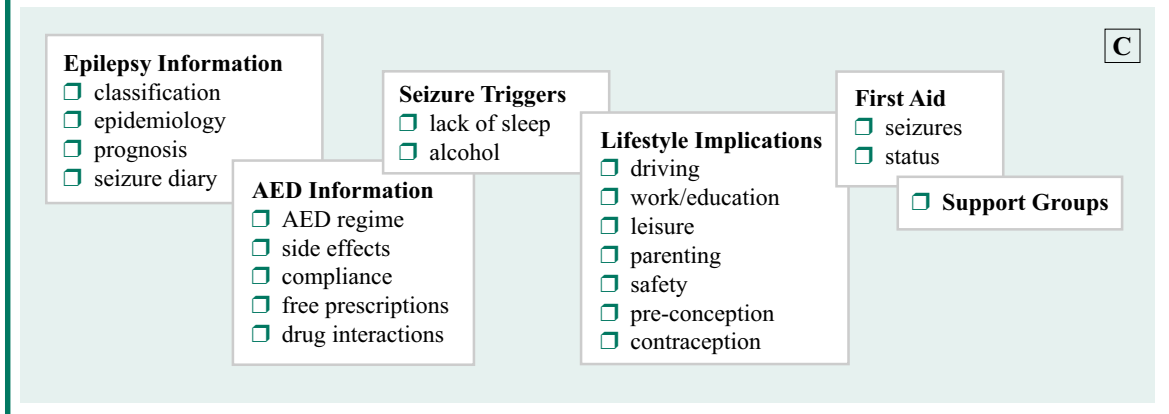
SIGN Secretariat, 9 Queen Street, Edinburgh, EH2 1JQ

This Quick Reference Guide was issued in November 1997 and will be reviewed in 1999

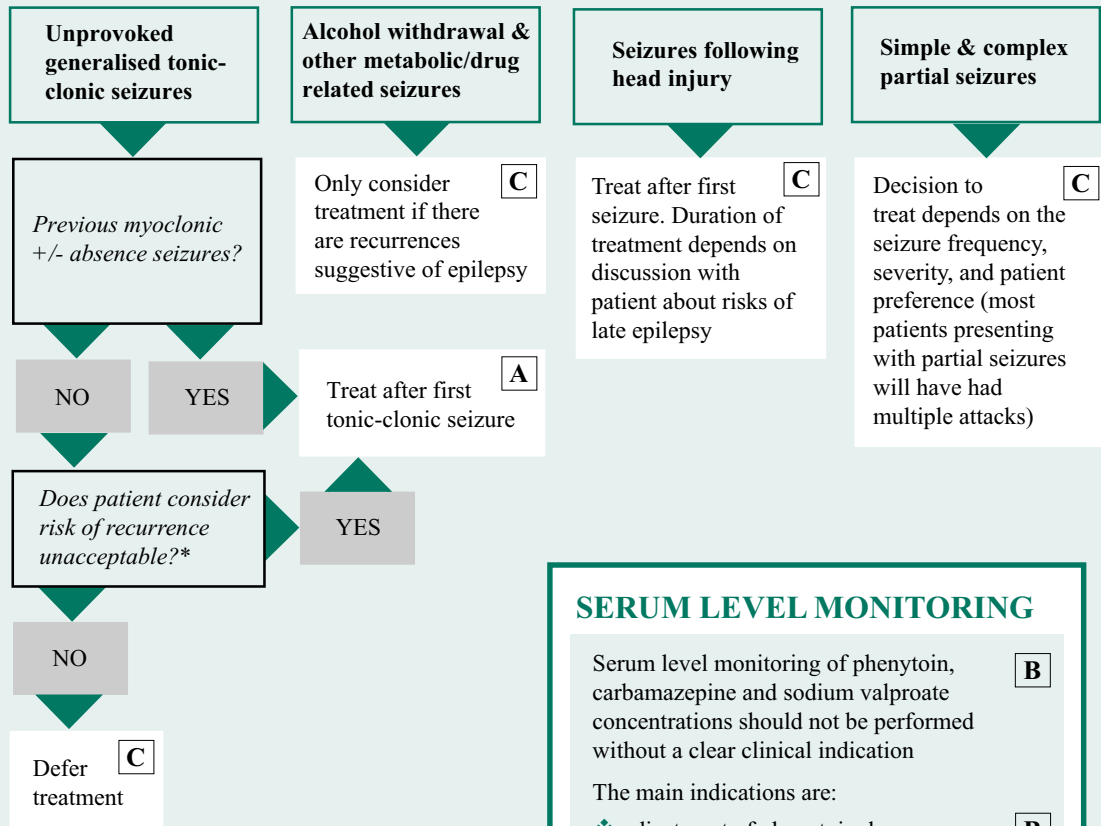
CLASSIFICATION AND INVESTIGATION



COUNSELLING CHECKLIST



WHEN TO START ANTIEPILEPTIC DRUG (AED) THERAPY



- * ❖ If seen within a week of first seizure, risk of recurrence is 67-80%
- ❖ If seen after a delay, risk may fall to 20-30%
- ❖ Treatment of patients with tonic-clonic seizures without a clear metabolic or structural cause may reduce risk of recurrence from 51 to 25%

SERUM LEVEL MONITORING

Serum level monitoring of phenytoin, carbamazepine and sodium valproate concentrations should not be performed without a clear clinical indication **B**

The main indications are:

- ❖ adjustment of phenytoin dose **B**
- ❖ assessment for compliance in patients with apparently refractory seizures **C**
- ❖ assessment of possible toxic symptoms **C**

With the above exceptions, serum level monitoring should *not* be used to adjust dosage. The effectiveness of sodium valproate does not correlate with serum levels **C**

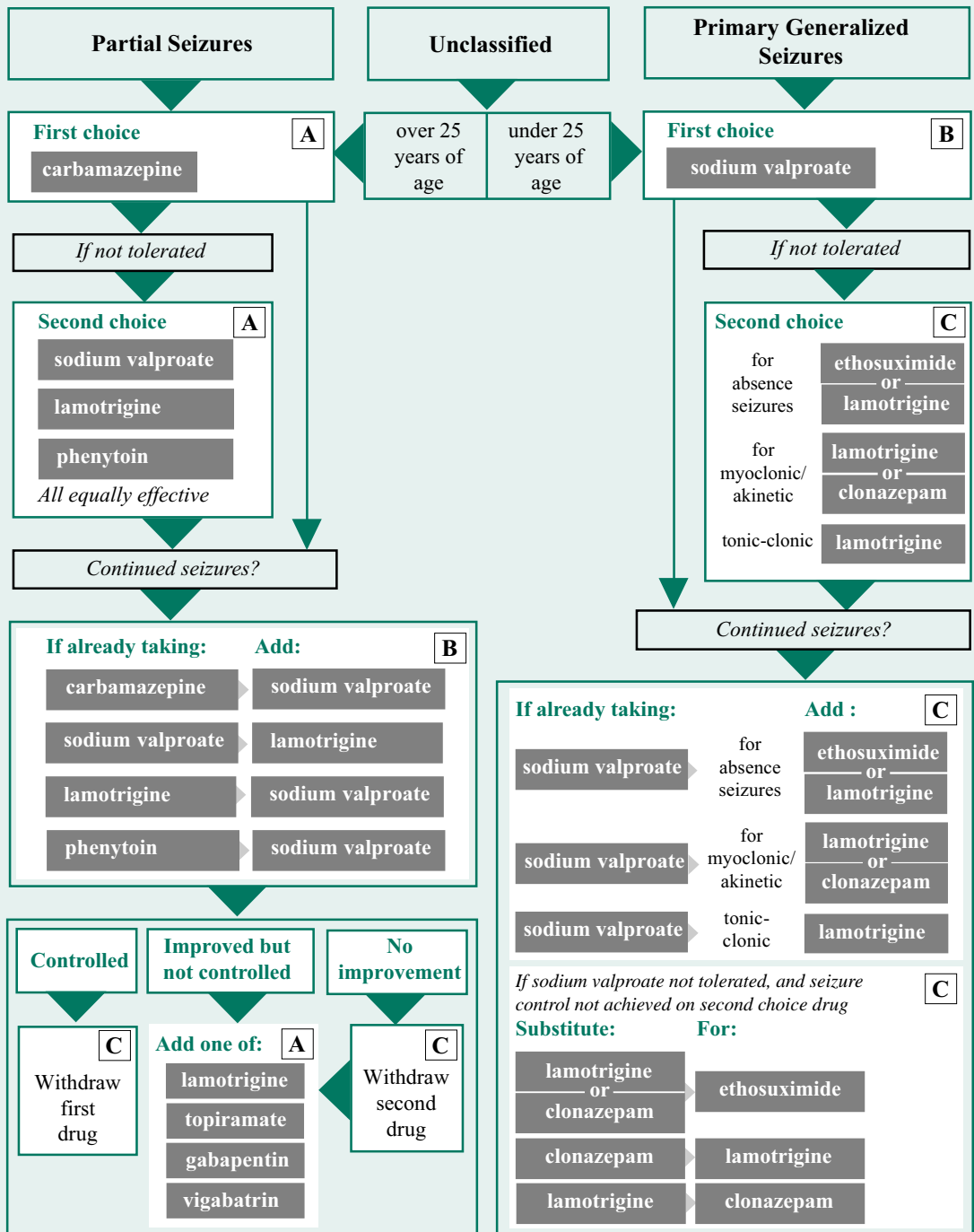
WHEN TO STOP ANTIEPILEPTIC DRUG THERAPY

- ❖ Withdrawal of AED medication can be discussed with patients after two years free of seizures, with reference to the prognostic index shown in tables 1 and 2 of Section 7 of the guideline **A**

Discussion of whether to withdraw AEDs should take into account: **C**

- ❖ the patient's need to work and drive a motor vehicle
- ❖ the patient's fear of seizures and attitude to prolonged AED therapy

CHOICE OF ANTI-EPILEPTIC DRUG THERAPY



- ❖ Patients who continue to be drug resistant should be referred for assessment for epilepsy surgery C
- ❖ Aim to maintain patient on minimum number of drugs required to achieve adequate symptom control
- ❖ Always consider a trial withdrawal of previous drugs once symptoms are adequately controlled with an add-on drug