Epilepsy in Pakistan: National Guidelines for Clinicians

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Epilepsy in Pakistan: national guidelines for clinicians

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ABSTRACT

Introduction
Epilepsy is one of the most common chronic neurological disorders requiring prolonged treatments and drugs. According to The World Health Organization (WHO), epilepsy is one of those serious brain disorders that affect not only the individual but has a deep impact on the family and society in general. Approximately 50 million people are affected with epilepsy around the world, though proper epidemiological studies do not exist for Pakistan it is estimated that the prevalence of epilepsy is 9.99/1000. Highest prevalence is seen in people younger than 30 years of age, i.e. about 2 million people and 1/10th of the world burden of epilepsy is in Pakistan! The guidelines available in developed countries are gauged in a setting where epilepsy care is provided by epileptologists/neurologists. In Pakistan the scenario is different, there is only one neurologist for 1.4 million (14lac) population contrast to US where one neurologist for 26 thousand people. So there is a desperate need to adapt to alternate guidelines with strategies to provide epilepsy management at a primary care level and to standardize epilepsy care on a National level.

Methods
To form these guidelines we reviewed and adopted from many different available guidelines mainly
1. Local adaptations of the WHO recommendations
3. Updated ILAE evidence review of AEDs special report 2013
4. Existing guidelines in other low income countries
5. NICE, AAN, AES recommendations

Results
These guidelines consist of
1. The universally ILAE accepted definition and classification of epilepsy and Epileptic syndromes with A step wise approach to a patient with seizures and epilepsy in Pakistan.
2. Tables Selecting the right drug with evidence based references keeping in mind the cost and availability in Pakistan.
3. AED selection in special populations e.g. women, children and elderly.
In 2011 supported the use of LOLA for neuro-psychiatric studies. Bai et al concluded after meta-analysis of 8 studies that L Ornithine L aspartate (LOLA) stimulates the urea cycle and ammonia utilization that's detoxification of ammonia. L Ornithine L aspartate (LOLA) ameliorated liver cirrhosis with significant decrease in serum ammonia levels and also obvious decrease in serum ammonia levels after infusion. Data was collected on the prescribed criteria, on day 1 before LOLA infusion and on day III, significant clinical improvement was observed p < 0.0001. Out of 100 patients in 2008 concluded that ornithine infusion improved the patients’ perceived quality of life.9 They stimulate urea cycle and glutamine synthesis, also in improving the patient’s perceived quality of life.9 Hyperammonemia and the severity of this disease, but also obvious decrease in serum ammonia levels, and also clinical improvement and shorter hospital stay.14 Ahmed et al compared the standard treatment, with LOLA and also observed. But these studies were of small sample size and ameliorated.4

CONCLUSION

The primary scope of these guidelines is to provide a concise practical management plan which considers the role of AEDs especially their judicial use. These guidelines hope to provide the physicians treating epilepsy patients with a step wise cost effective approach to the patient with epilepsy. A separate guideline to classification and diagnosis is also available, and the guidelines in entirety are also available on line at the Pakistan Society of Neurology website.

Guidelines Introduction

Epilepsy is one of the most common chronic neurological disorders requiring prolonged treatments and drugs. It is a disorder that is widely misunderstood and carries a vicious stigma. Epilepsy comprises a vast group of disorders and syndromes with one common symptom, “The Seizure”. For the purpose of these guidelines we have integrated the International League Against Epilepsy (ILAE) definitions of seizures and epilepsy. There is a vast array of literature and guidelines that exist in developed countries for over a decade. These have been reviewed and compiled and modified to suit the Pakistani population and socioeconomic status. These guidelines hope to help improve medical decision making in Pakistan while treating the patient with epilepsy (PWE).

THE NEED FOR NATIONAL GUIDELINES FOR EPILEPSY IN PAKISTAN:

Epilepsy has varied etiologies and affects all age groups, but the vast majority of cases are treatable with Anti Epileptic Drugs (AEDs) most of which are easily available. However knowledge about epilepsy and its care is extremely low. The majority of people with epilepsy (PWE) are treated inadequately or inappropriately. According to The World Health Organization (WHO), epilepsy is one of those serious brain disorders that affect not only the individual but has a deep impact on the family and society in general. Approximately 50 million people are affected with epilepsy around the world,4 and this number will increase with the new definition. Though proper epidemiological studies do not exist for Pakistan it is estimated that the prevalence of epilepsy is 9.99/1000. Highest prevalence is seen in people younger than 30 years of age.5 That is: about 2 million people and 1/10th of the world burden of epilepsy is in Pakistan. The recent estimates of population of Pakistan exceed 180 million, whereas the total number of trained neurologists in Pakistan is estimated to be 135 (Pakistan Society of Neurology Directory 2013)5. Based on the available data, the estimated 2 million people suffering from epilepsy in Pakistan, makes it one neurologist available for every 15200 sufferers of epilepsy with only few trained in epilepsy. Despite efforts to create awareness there remains a wide treatment gap and misconception. The guidelines available in developed countries are gauged in a setting where epilepsy care is provided by epileptologists/ neurologists. In Pakistan it is a different scenario, there is only one neurologist for 1.4 million population contrast to US where one neurologist for 26 thousand people6. So there is a desperate need to adapt to alternate guidelines with strategies to provide epilepsy management at a primary care level and to standardize epilepsy care on a National level. The primary care physicians in civil hospitals and dispensaries, and general practioners (GPs), form the crux of health care in Pakistan and therefore see most of the PWE. Unfortunately neurology rotation is not a mandatory in undergraduate training thus most lack the information and skill needed for proper epilepsy diagnosis and management. In 2011, WHO mental health Gap Action Programme (mhGAP) released evidence based epilepsy care guidelines for use in low and middle income countries4. These guidelines provide a crudePerforma that requires local adaptation for use within individual countries. The guidelines state “For effective implementation and sustainabilit, the sense of ownership and empowerment must be transferred from the global health authorities to the local people. Socio-cultural and financial barriers that impede the implementation of the guidelines should be identified and ameliorated.4
Table 1: Factors to consider while developing National guidelines.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Developed country</th>
<th>Developing country like Pakistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross National income</td>
<td>&gt; USD 3036</td>
<td>&lt; USD 565</td>
</tr>
<tr>
<td>Access to Health care</td>
<td>Primary care for all with established referral systems</td>
<td>Limited to very basic primary care</td>
</tr>
<tr>
<td>Health care funding</td>
<td>National programs and private insurance systems</td>
<td>Often ill funded rely on donors or volunteers. No set system of insurance</td>
</tr>
<tr>
<td>Cultural perception of seizures</td>
<td>Biomedical model</td>
<td>Traditional medicine, spiritual approach, contagion belief common</td>
</tr>
<tr>
<td>Common Epilepsy etiologies</td>
<td>Ideopathic, neoplastic cerebrovascular</td>
<td>Post infectious, antenatal, post traumatic</td>
</tr>
<tr>
<td>Socio-cultural attitudes towards epilepsy</td>
<td>At lease social presentation of neutrality</td>
<td>Overt negative public perception, stigmatization, and discrimination common</td>
</tr>
<tr>
<td>Treatment gap</td>
<td>&lt;20%</td>
<td>70-94%</td>
</tr>
</tbody>
</table>

ARIAIBLES AFFECTING SELECTION OF AEDS IN PAKISTAN

Epidemiological studies of prevalence and incidence reviewed are problematic in Pakistan due to lack of proper data collection teams and resources. Data concerning seizure type, etiology, and severity of seizures are contrasted with those from developed countries. Sociocultural aspects of epilepsy have been poorly studied, and yet are fundamental to effective medical management. Thus the principles and success of treatment in Pakistan may differ considerably from developed countries. The principles of drug therapy may not be understood by patients, and the supply of drugs is often erratic; and these are major reasons for poor compliance with treatment. Therapy need to be prioritized to cost effectiveness, requiring a cheaper drug eg, phenobarbital to be tried as first line contrary to international guidelines. Computations of treatment gap figures in three developing countries suggest that between 80-94% of patients with active epilepsy are not receiving anticonvulsant therapy, cost and cultural belief are two of the main factors.
**Table 2:** Factors affecting AED selection

<table>
<thead>
<tr>
<th>AED-specific variables</th>
<th>Patient-specific variables</th>
<th>Nation-specific variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizure type or epilepsy syndrome</td>
<td>Genetic background</td>
<td>AED availability</td>
</tr>
<tr>
<td>specific efficacy or effectiveness</td>
<td>Age</td>
<td>AED cost</td>
</tr>
<tr>
<td>Dose-dependent adverse effects</td>
<td>Gender</td>
<td>Insurance coverage</td>
</tr>
<tr>
<td>Idiosyncratic reactions</td>
<td>Comedications</td>
<td>Socio-cultural issues</td>
</tr>
<tr>
<td>Chronic toxicities</td>
<td>Comorbidities</td>
<td>Compliance</td>
</tr>
<tr>
<td>Teratogenicity</td>
<td>Insurance coverage</td>
<td></td>
</tr>
<tr>
<td>Carcinogenicity</td>
<td>Ability to swallow pills/tablets</td>
<td></td>
</tr>
<tr>
<td>Pharmacokinetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction potential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To form these guidelines we reviewed and adopted from many different available guidelines mainly.

1) Local adaptations of the WHO recommendations (4)
2) Modification of the ILAE treatment guidelines: based analysis of AEDs 2006 (11)
3) Updated ILAE evidence review of AEDs special report 2013 (12)
4) Existing guidelines in other low income countries (13,14,15,16)
5) NICE guidelines (17)
6) AAN practice parameters, (18)
7) AES recommendations (19)
8) A multitude of literature to support our selection and recommendations (20-43)

**Management Guidelines:**

**QUESTIONS ADDRESSED**

**Q1-Q3:** AEDs Initiation of therapy/Mono therapy; Adjuvant therapy; Cessation of therapy

**Q4-Q7:** Women (fertility, contraception, conception, pregnancy, lactation, teratogenicity), Children, elderly differences

**Q8-Q9:** Status Epilepticus in Adults and children (protocols)

**Q10-Q13:** Access to medications, direct and indirect costs, co-morbid conditions, preventable causes

**Q14-Q15:** Alternate Therapies, diet.

**Q16:** Epilepsy surgery.

**Q17-Q19:** Lifestyle, Career choices, Driving.

**Q20-23:** Epilepsy Diaries, lockets, keychain or bracelets, Help line.

**Monotherapy Guideline questions:**

**Q1-Q3:** Patients (adults/elderly/children) with partial-onset seizures

**Q4-Q5:** Patients (adults/children) with generalized-onset tonic-clonic seizures

**Q6:** Children with idiopathic localization-related epilepsies and syndromes (BECTS).

**Q7-Q8:** Children with idiopathic-generalized epilepsies (CAE, JME).

**Q9:** Special Issues related to Women.

**Q10:** Considerations in Elderly and Multiple handicapped

Questions 6-10 are discussed in the special population subset of these guidelines not published in this edition.

**A person is considered to have epilepsy if they meet any of the following conditions:**

At least two unprovoked (or reflex) seizures occurring greater than 24 hours apart.
One unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%) after two unprovoked seizures, occurring over the next 10 years.
Diagnosis of an epilepsy syndrome
For Classification and Diagnosis guidelines see Appendix A

MANAGEMENT OF EPILEPSY

Non-pharmacological Management:

Once diagnosis is made patient and family members need to be counselled empathically. Since the disease still carries a strong stigma, confidentiality needs to be maintained at all steps, and the condition should be discussed with any family member with consent of the PWE.

- Establish the diagnosis
- Education/ counselling
- Address psychosocial issues
- Lifestyle modifications

Patients need counselling regarding the

- Disease
- Diagnosis
- Need for medication
- Compliance
- Life style

Life style modification includes

- Adequate sleep - early to bed early to rise
- Change in job e.g. occupation, driving, swimmers, boxers, airplane pilots etc.
- Avoidance of alcohol, stimulants, energy drinks, gutka, JM, etc.
- Stress reduction — specific techniques, Yoga, meditation, early morning walks
- Adequate diet – high protein. Low carbohydrate, Vit. D, B rich diet
- Joining support groups
- Avoid social isolation

Pharmacological treatment of epilepsy

The mainstay of treatment for epilepsy is antiepileptic drugs (AEDs) taken daily to prevent the recurrence of epileptic seizures. It is important that the treatment strategy and suitability of the AED is determined by the prescriber keeping the individual with epilepsy and the carer informed before drug therapy is started.

When to Start AEDs after first seizures

Whether to treat first seizure is controversial studies show 16-62% recur within 5 years, Relapse rate is reduced by antiepileptic drug treatment, and it is now recommended that since Neurological abnormalities, abnormal imaging, abnormal EEG or family history increase relapse risk these patients should be treated after first seizure.

(Table 4)

<table>
<thead>
<tr>
<th>Definitely:</th>
<th>Possibly:</th>
</tr>
</thead>
<tbody>
<tr>
<td>With structural lesion like Brain tumor, AVM, Infection,</td>
<td>Unprovoked seizure</td>
</tr>
<tr>
<td>Without structural lesion: No Epilepsy in sibling EEG with definite pattern. Prior but remote sz prior neurological hist. Todds post ictal paresis status epilepticus at onset.</td>
<td>Possibly:</td>
</tr>
<tr>
<td>Probable not:</td>
<td></td>
</tr>
<tr>
<td>Alcohol withdrawal Drug abuse</td>
<td></td>
</tr>
<tr>
<td>Sz with acute illness post impact seizure</td>
<td></td>
</tr>
<tr>
<td>A benign epilepsy syndrome. Excessive sleep deprivation.</td>
<td></td>
</tr>
</tbody>
</table>

AED should be selected according to suitability of the patient, type of epilepsy etc.

Table 3 shows factors determining suitability.

Table 5

<table>
<thead>
<tr>
<th>Factors determining AED suitability include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>seizure type and/or epilepsy syndrome; childbearing potential; the presence of comorbidity; individual and/or carer preferences; the presence of contraindications to the drug; potential interactions with other drugs; potential adverse effects the licensed indication of the drug. Cost of AED Patients socio-economic status Age Compliance AED availability Adult lifestyle</td>
</tr>
</tbody>
</table>

The diagnosis of epilepsy needs to be critically evaluated if events continue despite an optimal dose of a first line AED. Before combination therapy is considered, PWE should be given a trial of at least 2-3 appropriate monotherapy regimens, with caution during the transition.

General Recommendations:

1) It is recommended that PWE should be treated with a single AED (monotherapy). If the initial treatment is unsuccessful, then monotherapy using another drug can be tried.
2) Caution is needed during the changeover period, with the second drug titrated and the first drug decreased gradually.

3) It is recommended that combination therapy (adjunctive or ‘add-on’ therapy) should only be considered when attempts at monotherapy with AEDs have not resulted in seizure control.

4) If trials of combination therapy do not bring about worth while benefits, Diagnosis should be revisited and treatment should revert to the regimen with best control providing efficacy in reducing seizures and tolerability of side effects.

5) Refer to specialist for phase II evaluation and Epilepsy surgery, classify and diagnose cause of refractory epilepsy, epileptic or non-epileptic fits.

6) If an AED has failed because of adverse effects or continued seizures, a second drug should be started (which may be an alternative first-line or second-line drug) and built up to an adequate or maximum tolerated dose and then the first drug should be tapered off slowly.

7) If the second drug is unhelpful, either the first or second drug may be tapered, depending on relative efficacy, side effects and how well the drugs are tolerated before starting another drug.

8) It should be recognised that some PWEs (through their families in some instances) may choose not to take AED therapy following a full discussion of risks and benefits. Reason should be sought and addressed accordingly. Treatment should be insisted upon if risk of recurrence is high as described in table 3.

9) Treatment of a first unprovoked seizure reduces the risk of recurrence in the short-term. In children, treatment of a first unprovoked seizure does not alter the long-term prognosis for seizure remission.

10) AED therapy should only be started once the diagnosis of epilepsy is confirmed, except in exceptional circumstances that require discussion and agreement between the physician and the PWE and/or carers as appropriate.

11) Continuing AED therapy should be planned by the physician. It should be part of the PWE agreed treatment plan, which should include details of how specific drug choices were made, drug dosage, possible side effects, and action to take if seizures persist.

12) When possible, choose which AED to offer on the basis of the presenting epilepsy syndrome. If the epilepsy syndrome is not clear at presentation, base the decision on the presenting seizure type(s).

13) Consistent supply to the PWE of a particular manufacturer’s AED preparation is recommended. Different preparations of some AEDs may vary in bioavailability or pharmacokinetic profiles and care needs to be taken to avoid reduced effect or excessive side effects.

14) Where partial seizures are suspected prefer sodium channel blockers as first line AEDs (see fig 1)

15) Where generalized seizure syndromes are suspected consider broader spectrum AEDs (see fig 1)

16) Phenobarbitone is a broad spectrum efficacious AED that is easily available in Pakistan at minimal price, therefore should still be considered as first line therapy where affordability is an issue as risk of seizures outweigh the long term side effects.

17) Phenobarbitone should be offered where compliance due to cost is suspected.

18) If using carbamazepine, check LFTs.

19) When prescribing sodium valproate to women nd girls of present and future childbearing potential, discuss the possible risk of malformation and neurodevelopmental impairments in an unborn child, particularly with high doses of this AED or when using as part of polytherapy. Vit B, folate and calcium supplements should be added.

20) Lamotrigine should be administered with caution and slow titration when given as monotherapy and with even slower titration when combined with inducers like valproate to avoid the risk of idiosyncratic reactions like Steven Johnson’s syndrome and toxic epidermolysis. All patients should be counseled and warned to stop medication and contact the physician immediately if any rash appears.

21) Levitiracetam should be given with neuropsychiatric issues in mind and pyridoxine supplement.

22) Maintain a high level of vigilance for treatment emergent adverse effects (for example, bone health issues, blood dyscrasias, and neuropsychiatric issues).
23) If management is complicated, PWE should be referred to specialist.
24) The prescriber must ensure that the PWE and/or carers as appropriate are fully informed about treatment including action to be taken after a missed dose or after a gastrointestinal upset.
25) Regular blood test monitoring in PWE is not recommended as routine, and should be done only if clinically indicated or non-compliance is suspected as below.

**Examples of blood tests include:**
Before surgery – clotting studies in those on sodium valproate. For Patients on enzyme inducing AEDs: CBC, Electrolytes, LFTs, Vit D levels, every 1-2 years. Test for serum amino acids, TSH and urine for organic acids in all children with neonatal non-infectious seizures and refractory seizures.
26) Asymptomatic minor abnormalities in test results are not necessarily an indication for changes in medication.
27) Every patient when stable should still have a 6 monthly follow-up to ensure compliance, and review treatment plan and side effects.
28) For uncontrolled patients treatment should be reviewed at regular intervals so PWE are not maintained for long periods on treatment that is ineffective or poorly tolerated, when in doubt early referral is more cost effective
29) **Compliance can be optimized with the following:**
- Educating PWE and their families and/or carers in the understanding of their condition and the rationale of treatment
- Reducing the stigma associated with the condition
- Using simple medication regimens
- Positive relationships between healthcare professionals PWE, and their family.
- SMS bulk reminder module

30) The risks and benefits of continuing or withdrawing AED therapy should be discussed with PWE and/or carers as appropriate, who have been seizure free for at least 2 years. At the end of the discussion, they should understand their risk of seizure recurrence off treatment. This discussion should take into account details of the PWE’s epilepsy syndrome, prognosis and life style.
31) When AED treatment is being discontinued in PWE who has been seizure free, it should be carried out slowly (at least 2-3 months) and one drug should be withdrawn at a time.
32) Particular care should be taken when withdrawing benzodiazepines and barbiturates (may take up to 6 months or longer) because of the possibility of drug-related withdrawal symptoms and/or seizure recurrence.
33) PWE and carer should be counseled whereby if seizures recur the last dose reduction is reversed and medical advice is sought.

**Table 6:** List of available AED’s worldwide vs those available in Pakistan with abbreviations, dosage, indication and common side effects.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Usual Starting Dose</th>
<th>Titrated Up or Down By</th>
<th>Usual Maximum Daily Dose</th>
<th>Common Side Effects</th>
<th>Summary Of Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetazolamie (AZM)</td>
<td>250 mgs bd</td>
<td>250 mgs every 1/52</td>
<td>1000 mgs daily in divided doses</td>
<td>GIT Dist. U&amp;E Dist. † urine output</td>
<td>Adjunctive for all sz types especially drop attacks</td>
</tr>
<tr>
<td>Carbamazepine (CBZ)</td>
<td>100-200 mgs 1-2 times daily 2-3mgs/kg/day</td>
<td>100 mgs every 1/52</td>
<td>2000 mgs daily in divided doses 10-20mg/kg/day</td>
<td>GIT Dist. #Rash Hyponatremia agranulocytosis</td>
<td>Mono/adjunctive therapy. Worsens myoclonic and absence seizures</td>
</tr>
<tr>
<td>Clobazam (CBZ)</td>
<td>5-10 mgs daily</td>
<td>5-10 mgs every 1/52</td>
<td>Up to 60 mgs daily</td>
<td>Drowsiness</td>
<td>Adjunctive for all sz type</td>
</tr>
<tr>
<td>Clonazepam (CLB)</td>
<td>0.5 mgs bd</td>
<td>0.5 mgs</td>
<td>8 mgs daily</td>
<td>Drowsiness</td>
<td>Mono/adjunctive for all sz types</td>
</tr>
</tbody>
</table>
ENCEPHALOPATHY, CAUSES BOTH CLINICAL AND BIOCHEMICAL STUDIES. BAI ET AL CONCLUDED AFTER META-ANALYSIS OF 8 INFUSION OF LOLA. THESE RESULTS WERE COMPARABLE TO OTHER BUT ALSO OBVIOUS DECREASE IN SERUM AMMONIA LEVELS AFTER EFFECTS NOT ONLY IN CLINICAL IMPROVEMENT OF ENCEPHALOPATHY DETOXIFICATION OF AMMONIA. L ORNITHINE L ASPARTATE (LOLA)

Grade III and 10(20%) were in grade IV hepatic encephalopathy. In placebo group on day 1 mean ammonia level was 110.52 micromol/L. On comparison of range: 6-47 micromol/l). In placebo group mean value < 0.05. (Table: III)

Nauea and vomiting and is easily available, can be given other standard therapies of hepatic encephalopathy since concluded that LOLA was safe and associated with rapid clinical recovery and decrease a study in Agha Khan university Hospital on 110 patients

<table>
<thead>
<tr>
<th>Table I:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONCLUSION</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diazepam (DZP)</th>
<th>5-10mgs daily</th>
<th>2.5-5mgs</th>
<th>30mgs per day</th>
<th>Drowsiness</th>
<th>Prolonged/cluster seizures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethosuximide* (ESM)</td>
<td>250 mgs bd</td>
<td>250 mgs every 1/52</td>
<td>2000 mgs daily</td>
<td>GIT Dist.</td>
<td>Drowsiness</td>
</tr>
<tr>
<td><strong>Felbamate</strong></td>
<td>300 mgs tds</td>
<td>300 mgs every 1/52</td>
<td>3600 mgs daily in divided doses</td>
<td>Liver Failure and aplastic anemia rare risk 1:5000</td>
<td>Adjunctive for all Szs types which have failed all other AEDs. Used under strict specialist supervision</td>
</tr>
<tr>
<td>Gabapentin (GBT)</td>
<td>200-300 mgs tds</td>
<td>200-300 mgs every 1/52</td>
<td>3600 mgs daily in divided doses</td>
<td>GIT Dist. Weight Gain</td>
<td>Mono/adjunctive for partial onset sos +/- sec gen</td>
</tr>
<tr>
<td>Lacosamide (LCM)</td>
<td>Initially 50mgs bd 1-2mg/kg/day</td>
<td>Increase weekly by 50mg bid</td>
<td>200mgs bd or 6-9mg/kg/day</td>
<td>Nausea, dizziness, somnolence, headache</td>
<td>Adjunctive for partial onset sos +/- sec gen</td>
</tr>
<tr>
<td>Lamotrinine (LTG)</td>
<td>25 mgs od 25 mgs alternate days When on VPA To a target dose of 100mgs BD Children 0.5mg/kg/day</td>
<td>25 mgs every week in children with VPA 1-5 mg/kg/day Without VPA 2-10mg/kg/day</td>
<td>500 mgs daily Children 10mg/kg/day</td>
<td>#Rash Insomnia GIT Dist. Headache Tremor with VPA</td>
<td></td>
</tr>
<tr>
<td>Levetiracetam (LEV)</td>
<td>250 mgs bd 250mgs od if Adjunctive therapy 10mg/kg/day</td>
<td>250-500 mgs every week</td>
<td>3000 mgs daily (1.5g bd) 20-60mg/kg/day</td>
<td>Psychosis Low Mood GIT</td>
<td>Mono/adjunctive for all sz types</td>
</tr>
<tr>
<td>Lorazepam (LZP)</td>
<td>1-2 mgs daily</td>
<td>1-2 mgs</td>
<td>4 mgs daily</td>
<td>Drowsiness Dependence</td>
<td>Adjunctive for all sz types Rescue use.</td>
</tr>
<tr>
<td>Midazolam</td>
<td>10 mgs daily</td>
<td>N/A</td>
<td>20 mgs</td>
<td>Drowsiness</td>
<td>For prolonged or clusters of all szs. Rescue use Status Epilepticus</td>
</tr>
<tr>
<td>Oxcarbazepine (OXC)</td>
<td>Initially 300mgs twice daily</td>
<td>Increased according to</td>
<td>2400 daily in divided doses</td>
<td>Encephalopathy Neutropenia</td>
<td>Mono/adjunctive for partial onset Szs +/- sec gen</td>
</tr>
</tbody>
</table>

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Ammonia is thought to play a major role in pathogenesis. The over encephalopathy. In the review of local data, improved the patient's perceived quality of life. Over last 25 years, various studies were carried out which are major mechanisms of ammonia detoxification. Another meta-analysis done in 2009 reviewed four studies and concluded that LOLA was associated with decreasing major complications of cirrhosis. Various neurotoxins common causes includes HBV, HCV, and alcoholic liver injuries. Encephalopathy was diagnosed on the basis of confusion, drowsiness, restlessness, disorientation and inverse albumin /globulin ratio. Hepatic Encephalopathy were included in the study after informed consent. CLD was diagnosed by common medical and dental college, a randomized, placebo-controlled study to observe effect of LOLA on clinical improvement observations. But these studies were of small sample size imbalance, prolonged prothrombin time were treated...
but also obvious decrease in serum ammonia levels after why thought to be useful in acute hepatic encephalopathy. The stimulation of the urea cycle and ammonia utilization for detoxification of ammonia. L-Ornithine L-aspartate (LOLA) is a major cause of hepatic encephalopathy, that’s why 12(24%) were in grade II, 19(38%) were in grade III, and 23(46%) were in grade IV hepatic encephalopathy. Used clinical grading of hepatic encephalopathy. In a trial of L-ornithine L-aspartate therapy, the difference was in serum ammonia levels before (day 1) and after (day 3) range: 6-47 micromol/l. In the placebo group, mean value < 0.05. (Table III)

Improvement as well as decreasing levels of ammonia.21

Both orally and parenterally and does not add significant nausea and vomiting and is easily available, can be given to identify two clinical trials. In 2011 Abid et al conducted a study to observe effect of LOLA on clinical improvement in patients with hepatic encephalopathy. LOLA is effective in decreasing serum ammonia as well as causes clinical improvement in patients with hepatic encephalopathy. 3,4 In hepatic encephalopathy, Acid (GABA) have been strongly associated with acute or chronic hepato-cellular failure and ammonia is thought to play a major role in pathogenesis associated with acute or chronic hepato-cellular failure. It also explains the reason why some patients with cirrhosis or end-stage liver disease are descendants of hepatic encephalopathy. They stimulate urea cycle and glutamine synthesis, concluded that LOLA was effective not only in reducing the over encephalopathy. In the review of local data, assessed the role of LOLA in minimal encephalopathy, not the over encephalopathy. In the review of local data, assessed the role of LOLA in minimal encephalopathy, not the over encephalopathy. In the review of local data, assessed the role of LOLA in minimal encephalopathy, not the over encephalopathy.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Effect</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenytoin (PHT)</td>
<td>150-300 mgs daily 5 mgs/kg/day</td>
<td>Increased gradually as necessary (with plasma phenytoin concentration monitoring)</td>
<td>Usual dose is 200-500 mgs daily 10-15 mgs/kg/day</td>
</tr>
<tr>
<td>Phenobarbitone (PB)</td>
<td>30 mgs daily</td>
<td>15 mgs every month</td>
<td>180 mgs daily</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Initially 25 mgs bd</td>
<td>50 mgs every 1/52</td>
<td>600 mgs daily In divided doses</td>
</tr>
<tr>
<td>Primidone* (PMD)</td>
<td>Initially 125 mgs at bed time</td>
<td>Increased by 125 mgs every 3 days to 500 mgs daily in 2 divided doses (250 mgs bd), then increased according to response by 250 mg s every 3 days</td>
<td>1500 mgs daily In 2 divided doses</td>
</tr>
<tr>
<td>Rufinamide*</td>
<td>200 mgs BD daily</td>
<td>200 mgs every 1/52</td>
<td>1600 mgs BD daily</td>
</tr>
<tr>
<td>Tiagabine* (TGB)</td>
<td>5 mgs bd</td>
<td>5-10 mgs every 1/52</td>
<td>30-45 mgs daily (doses above 30 mgs given in 3 divided doses)</td>
</tr>
<tr>
<td>Topiramate (TPM)</td>
<td>25 mgs daily 1 mgs/kg/day</td>
<td>25 mgs every 1/52</td>
<td>400 mgs daily (mono) In 2 divided doses 80 mgs (adjunctive) In 2 divided doses (6-9 mgs/kg/day)</td>
</tr>
<tr>
<td>Valproate (VPA)</td>
<td>300 mgs bd 5 mgs/kg/day</td>
<td>100-250 mgs every week</td>
<td>3000 mgs daily 15 mgs/kg/day</td>
</tr>
</tbody>
</table>
Not available in Pakistan or difficult to get
**Felbamate - Patients are usually electively admitted when initiating this AED due to the incidence of fatal liver failure and aplastic anaemia, for routine lab observation.

***Vigabatrin - Its use is restricted to whom all other combinations are inadequate or not tolerated. It must only be initiated by a Neurologist. All patients must have visual field testing prior to commencement and every 6/12 thereafter.

# Rash All AEDs carry the risk of rash, however the drugs highlighted as Rash carry a risk of Stevens - Johnsons Syndrome.

- Enzyme inducers and affect the metabolism of other drugs, for example Oral Contraceptives; women need to be alerted of this interaction.
- Weak enzyme inducers and may affect the metabolism of other drugs at high doses.
- Signs and Symptoms of Toxicity: vary from drug to drug however the following may indicate possible toxicity: Diplopia, blurred vision, unsteady gait, excessive tiredness, new onset of dizziness.
- GIT Dist may manifest as anorexia, nausea, vomiting dyspepsia, constipation, diarrhoea or any s/s of GI disturbance Interactions between antiepileptic drugs are complex and may enhance toxicity without a corresponding increase in antiepileptic effect. Interactions are usually caused by hepatic enzyme induction or hepatic enzyme inhibition. These interactions are highly variable and unpredictable.

### AED INTERACTIONS

Some common interactions between antiepileptic drugs and non-antiepileptic drugs are listed below in table 7. For a full list consult the PDR Summary of Product Characteristics for each drug.

**Note**

- Enzyme inducing AED’s increase the rate of metabolism of Warfarin and The INR should be monitored carefully when an enzyme AED is added or discontinued.
- Aspirin enhances valproate and phenytoin effects.
- Antibiotics, macrolides (clarithromycin/erythromycin) increase the plasma concentration of carbamazepine and inhibit the metabolism of phenytoin. Erythromycin possibly inhibits the metabolism of valproate.
- Meropenam, reduces plasma concentrations of valproate.
- Rifamycins accelerate phenytoin metabolism.
- Analgesics, NSAIDs enhance the effects of phenytoin.
- Estrogens, enzyme inducing drugs accelerate metabolism of Estrogens reducing contraceptive effects. Estrogens reduce lamotrigine levels.
- Plasma concentration of lamotrigine increased by valproate.
Another meta-analysis done randomized clinical trials including 646 patients that, infusion of LOLA. These results were comparable to other but also obvious decrease in serum ammonia levels after detoxification of ammonia. L Ornithine L aspartate (LOLA) most of the treatments are targeted against the Hepatic Encephalopathy is a common neuro-psychiatric cause clinical improvement in patients with hepatic LOLA is effective in decreasing serum ammonia as well as causes clinical improvement in patients with hepatic encephalopathy. Among these, raised level of hyperammonemia and the severity of this disease, but with minimal hepatic encephalopathy. A meta-analysis et al compared the standard treatment, with LOLA and showed controversial results. Blanco Over last 25 years, various studies were carried out which are major mechanisms of ammonia detoxification.8 Sharma et al conducted a study in 2014 and concluded that LOLA, probiotics and rifaxamine were all superior to standard treatment regimen.

### Table I: Distribution of patients according to characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Trial-Treatment Group</th>
<th>Placebo Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBs Ag+</td>
<td>56%</td>
<td>57%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>26%</td>
<td>26%</td>
</tr>
</tbody>
</table>

### Table II: To assess clinical improvement with LOLA

<table>
<thead>
<tr>
<th>Grade</th>
<th>Trial-Treatment Group</th>
<th>Placebo Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>10(20%)</td>
<td>17(34%)</td>
</tr>
<tr>
<td>II</td>
<td>12(24%)</td>
<td>10(20%)</td>
</tr>
<tr>
<td>III</td>
<td>19(38%)</td>
<td>17(34%)</td>
</tr>
<tr>
<td>IV</td>
<td>23(46%)</td>
<td>26(52%)</td>
</tr>
</tbody>
</table>

### Table III: Mean ammonia levels in various clinical stages

<table>
<thead>
<tr>
<th>Stage</th>
<th>Mean Ammonia Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>60 ± 10 micromol/l</td>
</tr>
<tr>
<td>II</td>
<td>45 ± 8 micromol/l</td>
</tr>
<tr>
<td>III</td>
<td>60 ± 10 micromol/l</td>
</tr>
<tr>
<td>IV</td>
<td>80 ± 15 micromol/l</td>
</tr>
</tbody>
</table>

### Table 7. Examples of important Drug interactions

<table>
<thead>
<tr>
<th>Agents</th>
<th>General interactions</th>
<th>Agents that may increase plasma levels</th>
<th>Agents that may decrease plasma levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine</td>
<td>The simultaneous administration of other licquid medicines with CBZ suspension can cause rubbery precipitate in stool. Co-administration with lithium can† neurotoxic SE. Other AEDs may alter thyroid functions. ↓es efficacy of hormonal contraceptives.</td>
<td>CYP 3A4 inhibitors Propoxiphene, Vigabatrin, VPA, protriptyline, loxopine, sertraline, ritonavir, nafmidone, isoniazid, verapamil, ketoconazole, cimetidine, flunerazine, viloxazine, macrolides, diltiazem</td>
<td>CYP 3A4 inducers, felbamate, PHT, mefloquin</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>CNS depressants, MAOIs, TCAs and some anti convulsants may increase depressant effects of CNZ. With VPA in Absence seizures can induce absence status!</td>
<td>CYP 3A inhibitors Azole antifungals, cimetidine</td>
<td>CBZ</td>
</tr>
<tr>
<td>Divalproate Sodium, Valproic acid</td>
<td>Drugs that elevate expression of hepatic enzymes increase the clearance of valproate. It increases free levels of warfarin</td>
<td>Asprin, felbamate, macrolides especially clarithromycin</td>
<td>Cholestyramine, meropenum, CBZ, PHT, PB, rifampin, Primidone, TPM</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Needs caution with other albumin binding drugs, PB, VPA, have un-predictable effect on levels. Antacids with calcium inhibit absorption. TCAs ↑risk for Sz.</td>
<td>CYP inhibitors, Azoles, trimethoprim, chloramphenicol, isoniazid, disulfiram, phenylbutazone, cimetidine, SSRI, felbamate, TPM, CBZ, ranitidine, ibuprofen, amiodrone, diltiazem.</td>
<td>CYP inducers, Rifampin, doxorubicin, VPA, vigabatrin.</td>
</tr>
</tbody>
</table>

**Fig 1:** Mechanisms of action of antiepileptic drugs modified from j. physiology 2006
Modified from j. primary psych 2005

Initiation of AEDs Drug choice with seizure type:

Treatment (Monotherapy) of patients with newly diagnosed focal (partial, complex partial and secondarily generalized) seizures:

A) Adults with focal(partial) onset seizures (ILAE 2013)

RECOMMENDATIONS

1) Offer CBZ/ OXC or PB (where cost is an issue) as first line treatment as first line treatment to patients with newly diagnosed focal seizures.
2) Offer LTG, PHT, OXC or VPA if CBZ and PB are unsuitable or not tolerated. If the first AED tried is ineffective, offer an alternative from these 5 AEDs. (Be aware of the teratogenic risks of sodium valproate and idiosyncratic rash of lamotrigine)

3) Consider adjunctive treatment if a second well tolerated AED is ineffective

4) If adjunctive treatment is ineffective or not tolerated, discuss with, or refer to, an epilepsy specialist or neurologist. Other AEDs that may be considered by the epilepsy specialist are eslicarbazepine acetate (ECA), clobazam, lacosamide, phenytoin, pregabalin, tiagabine, vigabatrin and zonisamide. Carefully consider the risk benefit ratio when using vigabatrin because of the risk of an irreversible effect on visual fields.

Table 8. Medication Selection In Patients with Focal onset seizures or symptomatic lesion related Epilepsies.

<table>
<thead>
<tr>
<th>1st line AEDs</th>
<th>2nd Line AEDs</th>
<th>3rd Line AEDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine CBZ</td>
<td>Levitiracetam LEV</td>
<td>Clonazepam CNZ</td>
</tr>
<tr>
<td>Phenytoin PHT</td>
<td>Valproate VPA</td>
<td>Tiagabin TGN*</td>
</tr>
<tr>
<td>Oxcarbazepine OXC</td>
<td>Topiramate TPM</td>
<td>Esi Carbazepine Acetate ECA*</td>
</tr>
<tr>
<td>Lamotrigine LTG</td>
<td>Gabapentine GBP</td>
<td>Zonisamide ZNS*</td>
</tr>
<tr>
<td>Phenobarbital PB</td>
<td>Lacosamide LCM</td>
<td>Perampanel*</td>
</tr>
</tbody>
</table>

*Not available in Pakistan

Table 9. Focal Seizures AED Selection guide by seizure type

<table>
<thead>
<tr>
<th>Clinical Situation</th>
<th>Simple Partial Sz</th>
<th>Complex Partial Sz</th>
<th>Secondary generalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Monotherapy</td>
<td>CBZ</td>
<td>CBZ</td>
<td>CBZ</td>
</tr>
<tr>
<td></td>
<td>OXC</td>
<td>OXC</td>
<td>PHT</td>
</tr>
<tr>
<td></td>
<td>PHT</td>
<td>PHT</td>
<td>OXC</td>
</tr>
<tr>
<td></td>
<td>LTG</td>
<td>LTG</td>
<td>LTG</td>
</tr>
<tr>
<td></td>
<td>LEV</td>
<td>LEV</td>
<td>VPA</td>
</tr>
<tr>
<td></td>
<td>ZNS</td>
<td>ZNS</td>
<td>LEV</td>
</tr>
</tbody>
</table>

Pharmacological management(monotherapy) of Adults with newly diagnosed Generalized Epilepsy Syndromes (IGE).

The absence of class I and II RCTs(randomized controlled trials) for adults with GTC seizures implies a marked deficiency in published studies. No AED has reached the highest level of evidence (level A and B) for efficacy. VPA, LTG, TPM, OXC, PB, PHT, TPM, and CBZ are possibly level C, and GBP, LEV, and VGB are
potentially level D efficacious/effective as initial monotherapy for adults with newly diagnosed or untreated generalized onset tonic-clonic seizures. Class IV evidence suggests that CBZ and PHT and other sodium channel blockers may precipitate or aggravate generalized onset seizures. (ILAE updates 2013).

RECOMMENDATIONS

1) Offer sodium valproate as first line treatment to adults with newly diagnosed GTCs. (Be aware of teratogenic risks of sodium valproate in women of child bearing age)

2) Offer lamotrigine if sodium valproate is unsuitable. If the person has myoclonic seizures or is suspected of having juvenile myoclonic epilepsy (JME), be aware that lamotrigine may exacerbate myoclonic seizures. Be aware of idiosyncratic reaction of lamotrigine by slow escalation)

3) Consider levitiracetam and Phenobarbital in patients where VPA and LTG are not suitable.

4) Offer clobazam, CBZ, OXC and TPM as adjunctive treatment to adults with GTC seizures if first line treatments as above are ineffective or not tolerated. (Be aware of the risk of exacerbating myoclonic or absence seizures with CBZ and OXC)

5) If there are absence or myoclonic seizures, or if JME is suspected, do not offer carbamazepine, gabapentin, oxcarbazepine, phenytoin, pregabaline, tiagabine or vigabatrin.

Table 10: Generalized Tonic Clonic Epilepsy – AEDs of choice

<table>
<thead>
<tr>
<th>1st line</th>
<th>2nd line</th>
<th>3rd line</th>
</tr>
</thead>
<tbody>
<tr>
<td>VPA</td>
<td>TPM</td>
<td>CNZ</td>
</tr>
<tr>
<td>LTG#</td>
<td>ZNS*</td>
<td>CBM</td>
</tr>
<tr>
<td>TPM</td>
<td>LEV</td>
<td>GBP</td>
</tr>
<tr>
<td>LEV</td>
<td>PB</td>
<td>CBZ#</td>
</tr>
<tr>
<td>PHT#</td>
<td>OXC#</td>
<td>VIGABATRIN ETHOSUXIMIDE</td>
</tr>
</tbody>
</table>

#Avoid in myoclonus  *not available in Pakistan

Table 11. Idiopathic Generalized Epilepsy: Medication Selection

<table>
<thead>
<tr>
<th>AED selection</th>
<th>Clinical situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GTC</td>
</tr>
<tr>
<td>Initial monotherapy</td>
<td>LPA</td>
</tr>
<tr>
<td>LTG</td>
<td>VPA</td>
</tr>
<tr>
<td>2nd Monotherapy if VPA failed</td>
<td>LTG</td>
</tr>
<tr>
<td>LEV</td>
<td>ESM</td>
</tr>
<tr>
<td>2nd Monotherapy if LTG/LEV failed</td>
<td>TPM</td>
</tr>
<tr>
<td>LEV</td>
<td>VPA</td>
</tr>
<tr>
<td>LTG</td>
<td>VPA</td>
</tr>
<tr>
<td>ZNS</td>
<td>ZNS</td>
</tr>
</tbody>
</table>

KETOREGENIC DIET

INTRODUCTION

The ketogenic diet (KD) is a high fat, low carbohydrate and protein diet designed to mimic the biochemical response of the body to starvation when ketone bodies become the main fuel for the brain’s energy demands (Hartman 2008). It has long been used in the treatment of refractory epilepsy in children, although the exact mechanism of action is unclear. The KD diet was initially reported for use in epilepsy in 1921 (Wilder 1921). The initial diet used was the classical ketogenic diet, based on the ratio of fat to carbo-hydrate (with protein), of 3 or 4:1. Later an alternative was suggested using triglyceride oil as a supplement, the Medium chain Triglyceride (MCT) Diet (Huttenlocher et al 1971). These diets have to be carefully administered with the aid of a dietician.

- There is no evidence of efficacy of ketogenic diet in adults.
- 50% efficacy range is achieved in children.
- Recommended in refractory epilepsies in children where multiple regimens of AEDs proven ineffective.
- Local ketogenic recipies are available and cost effective.

Epilepsy Surgery

**FDA approved surgical procedures:**

- Vagus nerve stimulation
- Surgical treatment

**Investigational:**

- Deep brain stimulation
- Gene therapy
Laser Ablation

Surgical Treatment

- Upto 85% seizure-free rates

Resections:
- Lesionectomy, lobectomy, hemispherectomy

Disconnections:
- Callosotomy, subpial transection, stereotactic ablations

Augmentations:
- Vagal, cerebellar, thalamic, deep brain stimulation

All patients with focal onset seizures that are refractory to an adequate trial of two or more AEDs of choice and are refractory to treatment should be referred for phase 1 surgical evaluation to an epilepsy specialist. All lesion-related Epilepsy syndromes should be considered for surgical management

SUMMARY:

These guidelines hope to highlight the problems that exist in the care and management of epilepsy patients like patient and physician awareness, social and cultural beliefs, easy access to treatment, misdiagnosis, inappropriate or inadequate treatment, sudden unexpected death that might have been prevented, preventable etiologies, women with epilepsy, epilepsy in children, epilepsy in the elderly, advice about pregnancy and contraception and management of status epilepticus in children and adults. These guidelines will be revisited and modified on applicability every four years and it is vital that a spotlight is kept on the need to further develop variable services for people with epilepsy. The place of newly licensed drugs, stigmas, and cost for epilepsy also needs careful consideration. The primary scope of these guidelines is to provide a concise practical management plan which considers the role of AEDs especially their judicial use. The role of established and newly licensed drugs is considered with comparison of cost effectiveness. People with epilepsy remain at the centre of this guideline, and the need for services to consider the needs of each individual and their caregivers have been focused. Attention has been paid to ensure that the recommendations are written in clear language and be accessible, and, I hope, useful to all. We remain committed to the care of people with epilepsy and commend these guidelines to you in that light.

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20. Women with epilepsy, evidence based guidelines for clinicians
21. Dosing and monitoring guidelines for Anticonvulsants edmedicine PP GiulioPerugi, MD, and Cristina Toni, MD, PhD
38. Engel J. A proposed diagnostic scheme for people with epileptic seizures and with epilepsy: report of the ILAE task force on diagnosis of epilepsy
The absence of class I and II RCTs (randomized controlled trials) for adults with newly diagnosed generalized epilepsy indicates a need for more evidence to support pharmacological management (monotherapy) of this condition. Recommendations are written in clear language and be particularly useful for those with refractory epilepsy in children and adults. The primary scope of these guidelines is to provide a concise practical management consideration. Factors predicting prognosis of epilepsy after remission of epilepsy: results from the National Epilepsy: the size of the problem. Seizure. 2001;10:55–60.

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Author’s contribution:

Dr. Fozzia Siddiqi: Study concept and design, protocol writing, data collection, data analysis, manuscript writing, manuscript review

Dr. Shaukat Ali: Data analysis, manuscript review

Dr. Tipu Sultan: Collection, data analysis, manuscript writing Child Epilepsy.

Dr. Shahid Mustafa: Data analysis, manuscript review.

Dr. Saleem Barech: Data collection, data analysis.

Dr. Sarwar Siddiqi: Manuscript writing, manuscript review

Dr. Abdul Malik: Data collection, manuscript writing

Dr. Zafar Sajjad: Manuscript writing, Seizure protocol neuroimaging, manuscript review

Dr. Rasheed jooma: Data analysis, manuscript writing Epilepsy Surgery, manuscript review

References:


