

# NICE Guidelines for Epilepsy Management

[www.nice.org.uk/CG020adultsquickrefguide](http://www.nice.org.uk/CG020adultsquickrefguide)

I welcome any guidelines that raise the profile of epilepsy and encourage improvements in care. The aims should be aspirational – there is no point writing a document that aims to perpetuate an unsatisfactory status quo. Will clinicians and managers be able to get together to implement these guidelines, especially given that in all probability there will be no resources to accompany the recommendations? Each year my children write a Christmas list and burn it in the fireplace in the hope that the ashes will magically reconstitute into the requested goodies on a return journey down the chimney on the night of December 24th. The question is: as the festive season approaches, should I go and talk to my manager or should I reach for the matches, guidelines in hand?

This document covers a broad remit of issues for epilepsy patients from diagnosis to long-term care. Perhaps the most interesting thing in the abridged NICE guidelines for epilepsy management is that only four recommendations are said to be supported by grade A evidence (randomised controlled trials): 1) treatment is generally recommended after a second seizure; 2) the value of rectal diazepam in status epilepticus; 3) unspecified psychological interventions for epilepsy and 4) the value of vagal nerve stimulation. All other recommendations rely on a poorer evidence base. This clearly says something about the science upon which we practice and the scientific rigour underpinning the guidelines.

They recommend that all patients with a suspected seizure should be seen within 2 weeks by a specialist and that EEG and neuroimaging should be undertaken within a further 4 weeks. MRI is clearly the recommended imaging modality. Whether this is truly necessary in all cases is in my view debatable, and in some cases speed of imaging may be a more important issue. For example in elderly patients the role of imaging may just be to rule out an obvious tumour. The guidelines helpfully provide reasons for not requesting an EEG as well as for requesting one, for example in patients with a clinical diagnosis of syncope where there may be false positive results. Where investigations remain uncertain, video-EEG-telemetry or ambulatory monitoring should be undertaken. These crucial resources are scarce in some areas and hopefully the guidelines will be a boost to them. Neuropsychology is recommended if there is a lesion in areas involved in cognitive function (virtually all imaging-positive patients) as well as those with symptomatic cognitive problems. Clearly this represents a massive increase in demand.

Treatment should generally be started after a second

seizure, although may be considered after a first seizure in patients at high risk of further seizures (e.g. with tumours) or those where seizures may carry a particularly high risk, for example for a patient taking warfarin. Monotherapy is recommended where possible and proprietary preparations rather than generics are also supported. A full blood count, renal function, liver function, vitamin D and other tests of bone metabolism are recommended every 2-5 years for patients taking enzyme-inducing drugs. Whilst I can understand anticipating osteoporosis, I am not sure how helpful these other tests will be. The issue of new drugs has been dealt with in a previous set of NICE guidelines, which gave clinicians a fairly free rein. Essentially carbamazepine and valproate are recommended first line unless the clinician feels differently, for example avoiding valproate in women of child-bearing age. There is no restriction on using newer AEDs if initial treatment fails but the importance of withdrawing unsuccessful treatment is pointed out, in order to prevent unnecessary polypharmacy.

There is a large section, 4 pages of the 18 page summary, devoted to a syndrome by syndrome analysis of drug efficacy which clinicians will find useful and a list of major adverse effects of each drug. If treatment works well then the patient should be reviewed annually either in the hospital or in general practice. If the patient's epilepsy proves refractory for 2 years, a tertiary referral is recommended and the patient should then be seen within 4 weeks. Whilst desirable that all patients are seen quickly, it does not make much sense to emphasise a 4 week limit for a patient whose problem has been going on for 2 years.

In the treatment of status epilepticus, the guidelines support the use of buccal midazolam as an alternative to rectal diazepam, although this use is currently unlicensed.

There is an appropriate emphasis on information for patients to cover every aspect of life and work and the role of the specialist nurse is stressed. Sudden unexplained death is highlighted and the view of NICE is that all adult patients should be informed and any preventive measure can be taken. The NICE guidelines emphasise current best practice for women of child-bearing age with epilepsy. They highlight the difficulties in diagnosis and management in patients with learning disability but do not give specific recommendations.

There is little to argue with in these guidelines. If they are enacted, our patients will receive a much better service from us. The key is implementation if they are not to go down in history as yet another puff of chimney smoke.



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For information on the NICE guideline for the Management of Multiple Sclerosis in Primary & Secondary Care, see [www.acnr.co.uk/pdfs/volume3issue6/v3i6specMSguide.pdf](http://www.acnr.co.uk/pdfs/volume3issue6/v3i6specMSguide.pdf) (ACNR volume 3, issue 6, Jan/Feb 2004).

## Letter to the Editor

Dear Editor,

This letter is in response to your review of our paper on the efficacy of vagal nerve stimulation therapy (VNST) in adults with medically refractory generalised epilepsy syndromes<sup>1</sup> ('Epilepsy: A shocking pain in the neck' *ACNR volume 4, issue 5*). The reviewer contends that the results are 'modest'. In fact, 7/16 patients had at least a 50% reduction in seizures, a clinical improvement that most logically can be attributed only to VNST, since antiepileptic drug (AED) regimens were held constant during the study period. This response is comparable to that observed in new AED trials. Moreover, although it is true that VNS will rarely result in seizure-freedom in patients where medications have failed, several of our patients did have a dramatic, meaningful reduction in debilitating tonic or atonic seizures, as the reviewer himself points out.

One should recall that all the subjects in this series had severe epilepsy for years, and most for decades, and had failed multiple drug trials. The epilepsy syndrome and seizure type for every patient was carefully established on

the basis of the history, clinical findings, EEG-video monitoring, and neuroimaging. None were candidates for epilepsy surgery. There was little else to offer in terms of treatment. The reviewer expressed a desire for 'useful selection criteria'. We respond that VNST may be a reasonable therapeutic option in patients with medically intractable epilepsy who are not good candidates for surgical therapy.

The clinical experience with VNST approaches nearly a decade, with over 30,000 patients worldwide having been treated with the device. Nearly all investigators report similar response rates to VNST, and note that the beneficial effects are maintained over time. While one may debate the precise role of VNST in epilepsy management, we doubt that it is likely to be simply a 'passing fad'.

1. Holmes M, Silbergeld D, Drouhard D, Wilensky A, Ojemann L. *Effect of vagal nerve stimulation on adults with pharmacoresistant generalized epilepsy syndromes*. *Seizure* 2004;13:340-345.

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