

DLAAB

Disability Living Allowance Advisory Board

NEWS & UPDATE.

INDEX

Topics for Future Issues of Update	page 1
Introduction by the Chair	page 2
Making a diagnosis of epilepsy	page 2
Dr Ronald Pearce	
DLAAB News	page 7
Invitation to DMs	page 8
Getting in touch	page 9

Topics for Future Issues

- ◆ Care of the older person in general practise
- ◆ Spina Bifida
- ◆ Extended stress after amputation
- ◆ Aphasia
- ◆ Chest pain/chest conditions
- ◆ Stereotypes

DM's suggestions for topics welcome. Please contact us.

INTRODUCTION BY THE CHAIR

Hello everyone,

I hope you enjoyed the last issue of DLAAB Up-date and News, and that you all have had a good summer. Here is the Autumn edition which I hope will prove to be of great interest. The Board makes every effort to bring you news and articles which are up-to-date in content and hopefully are useful to you in your work. Please let us know your views and comments on the topics we choose, and any other topics which you would like us to include in the future.

Anne Spaight
Chair of DLAAB

Making A Diagnosis of Epilepsy

Dr Ronald K B Pearce
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This article is the first of two. Care and mobility needs will be included in the next article.

Introduction

Epilepsy is a common neurological disorder affecting about 1 in 200 individuals (around 300,000 persons in the UK). The lifetime risk for a single epileptic seizure is 3-5%, but having a single seizure is not sufficient for a diagnosis of epilepsy, which indicates a tendency for repeated seizures. A seizure is an abnormal discharge of neurones. Epilepsy is not a specific diagnosis, with several specific types of seizure disorder. While most epilepsy begins in childhood or young adulthood, about 25% of new cases occur in the elderly. Seizures impact significantly on quality of life, with a diagnosis of epilepsy having profound psychological and social consequences. These include limitations on employment and driving, concerns in pregnancy and often the need to adhere with daily anticonvulsant drug treatment.

Fit or Faint?

It can be difficult to decide whether a collapse or episode of altered consciousness is indeed an epileptic attack. Obviously, this decision is made much easier with a reliable witness who reports abnormal muscular spasms and limb shaking, laboured breathing, forced deviation of the eyes along with tongue or lip biting and incontinence. Many attacks, however, do not paint so convincing a picture of a 'grand mal' or tonic clonic seizure (a major convulsion with clenching of muscles followed by repetitive jerking movements).

Thus, a common dilemma is to determine whether an attack of loss of consciousness represents an epileptic fit or fainting from other causes. A sudden loss of consciousness is in fact *syncope*. In some clinics up to 40% of seizure-like attacks can be due to syncope most often in the form of simple faints, low blood pressure and cardiac causes.

Prolonged confusion after losing consciousness suggests a seizure, but a few convulsive movements can also be seen when an individual faints, especially if they are prevented from lying down flat.

In young children one encounters breath holding attacks and also a type of convulsion associated with high fever (febrile convulsions).

Some individuals develop non-epileptic attacks also known as *pseudoseizures* or *dissociative attacks*, which can strongly resemble true seizures and can co-exist with a confirmed diagnosis of epilepsy.

Epileptic seizures can be produced by underlying physical problems e.g. strokes, brain tumours or blood vessel malformations, head injury, metabolic problems (such as low blood sugar or sodium). Thus, it is important to obtain a detailed medical history and conduct appropriate investigations when indicated. Some medical conditions will be obvious (for example meningitis or stroke) but often there is some difficulty in deciding whether a sudden episode of loss of consciousness or altered consciousness is epileptic or non-epileptic. Seizures are classified as either *simple* (without altered consciousness), or *complex* (with altered consciousness), *partial* (of focal onset in the brain) seizures or *generalised* (involving the whole of the brain) seizures. This terminology replaces older more complex diagnostic labels such as 'petit mal' (non-convulsive seizures with altered consciousness) and 'grand mal' (a full blown tonic clonic seizure). Several well-recognised syndromes exist, such as juvenile myoclonic epilepsy, and have specific drug treatment. A specific syndrome diagnosis can be made in about 80% with history, EEG and MRI.

Diagnostic tests

The main investigations pertinent to making the diagnosis of epilepsy and ruling out a serious underlying cause in the brain are brain imaging (CT or MRI scan) and the EEG (electro-encephalogram). Both of these tests can be negative in active epilepsy and thus the clinical history

remains of greatest importance. The EEG can indicate focal abnormalities and can help to define the risk of recurrence (which is lower with a normal study). If performed within a few days of a seizure, the EEG is abnormal in 70% of cases and there is a lower likelihood of detecting any abnormality with a longer delay. If the routine EEG is negative, then repeating the test after a night of sleep deprivation can detect epileptiform changes (abnormalities very suggestive of epilepsy) in up to an additional 30% of cases. MRI scanning is more sensitive to brain abnormalities than a CT scan and identifiable problems are more likely to be found in adults and especially the elderly.

Prognosis & Risk of Seizure Recurrence

The risk of having further epileptic attacks after a single seizure depends on the individual and whether the fit was provoked or unprovoked. A provoked seizure has a clearly identified cause such as alcohol withdrawal or head injury. About 25-30% of first seizures are provoked and symptomatic of acutely disturbed brain function with a low risk of recurrence (less than 10%). If with a provoked seizure there is some permanent brain damage, such as after a stroke, then the seizure risk is much higher, with about 10% of stroke patients having seizures after 5 years. There is a higher risk of future seizures also with an abnormal brain scan, an abnormal EEG, a family history of epilepsy, febrile convulsions in childhood, any abnormalities on physical examination and a presentation with repeated and continuous seizures, known as status epilepticus.

In general, if a seizure is unprovoked and without any obvious underlying cause there is a higher risk of recurrence. After a single unprovoked seizure there is a 30-50% risk of recurrence over two years with 60-70% of recurrences occurring within the first 6 months and if two unprovoked seizures occur then this risk increases to 70-80%. Certain circumstances can trigger seizures in susceptible individuals. Stress and sleep deprivation, alcohol and anaesthesia, for example, can unmask an underlying epileptic tendency. Other possible triggers include stroboscopic lights (disco lights), and rarely even highly specific activities such as reading or running. Patients with established epilepsy will also have similar 'triggers' that lead to seizures including forgetting to take medication (poor compliance). If there is any significant doubt in the making the diagnosis it is often best to wait and watch. A mistaken diagnosis of epilepsy can be more harmful than a few repeat attacks.

To Treat or Not to Treat

If a diagnosis of a seizure or several seizures has been confirmed then it is essential that one undertake counselling regarding the risks of recurrence and the benefits as well as potential side effects of treatment with anticonvulsant medication. Treatment is more likely helpful with a clear high risk of seizure recurrence and when there may be employment issues. Generally, after counselling most individuals decide not to go take medication after a single seizure.

All medications can have mild as well as serious potential physical and psychological side effects and impact on major life decisions such as pregnancy, with an increased risk of foetal malformations in women who take anticonvulsant medication. There are several drugs to choose from and treatment should be individually tailored.

After a single seizure, sensible guidelines would be to restrict recreational activities such as swimming and climbing for 2-3 months and working with dangerous machines for 6 months. In the UK driving is not allowed for 1 year after a seizure with more detailed advice also defined by the DVLA. For any individual with epilepsy there should be an opportunity for at least an annual clinical review by a Paediatrician, Neurologist or Epilepsy Nurse Specialist.

Long Term Prognosis

Anticonvulsant medication works well with 90% of patients seizure free in the last year and 70% seizure free over five years but there is a great range in fit control, with individuals having some form of brain damage often more difficult to treat successfully than seizures without any known cause ('idiopathic'). In children, who have been seizure free for one to two years one can often try to stop medication and this is probably true for adults as well. If medication is stopped slowly and there have been no seizures for at least two years then 60% of individuals will not have any further seizures. If fits do come back it is usually within the first two years.

Conclusion

This article has discussed some of the issues pertaining to arriving at a diagnosis of seizures and it is hoped that it will give a greater appreciation of the difficulty and complexity of this process and the implications for those who present to medical attention with the question of a possible fit.

DLAAB NEWS

MEETINGS WITH OUTSIDE ORGANISATIONS

The Board meets regularly with outside organisations. At these meetings Board members with relevant skills, expertise or interest have discussions with representatives of various groups.

The Board invites specific groups and also welcomes approaches from any group who feels it would benefit from meeting the Board. We have met representatives from MIND, the Scottish Mental Health Association and Aphasic.

We use the News and Update as a means of directly informing DM's of changes that are new or brought to the Board's attention. This is in addition to the information already available in the Disability Handbook.

Updates to the Disability Handbook are being made via ICT where appropriate. Meeting with the Board gives access to representatives of outside organisations to inform us of issues needing clarification.

NEWS

The Board has held a seminar for DMs at Warbreck House

Since the last issue Our Information and Development Group has been monitoring new developments and treatments for various conditions with the focus being on subsequent changes in the level of Care and Mobility needs.

Our website continues to include new publications by the Board and our latest Annual report is due to be published soon. We now have an internal search engine giving easy access to articles from all past issues of the News and Update as well as all Annual reports.

THE BOARD

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THE REMIT

The Board has three main functions:

- To give advice to the Secretary of State on matters referred by him/her.
- To give advice to Department of Work and Pensions Medical Services doctors on cases referred for expert advice.
- To present an Annual Report on its activities over the year to the Secretary of State.

INVITATION TO DM'S

If you have any specific questions or general queries please contact us via the Secretariat.

We wish to use the News & Update as a forum for discussion.

FOR YOUR INFORMATION

Please note- the articles contained in this news- sheet are written for the benefit of Decision Makers, to help them with their job.

The articles are **not to be quoted** in any decision or communication with members of the public or their representatives.

GETTING IN TOUCH

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