Comments on the "Revised terminology and concepts for organization of the epilepsies: Report of the Commission on Classification and Terminology"

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I can image that it is a hard work. Many good ideas from excellent brains may have been put into it. My comments and suggestions are:

1. The task of classification and terminology is a long-term hard job. It is not expected that many things were changed in a version or in a short period of time. We should also consider the acceptability of most of the epileptologists. Small steps with continuous improvement may be better than a big change, considering the continuation of application of classification in clinical practice. For instance, it seems that the classification of seizures in this version is more similar to that of 1981, not so much changes as that of 2001. A good lesson could be learnt from that. I am not meaning that the version of 2001 is not good. It is excellent, but less acceptable for most of the doctors at present. So, I think we should also have small steps for the change of classification of epilepsies and syndromes.

2. Extend from the first point, it should be very deliberate on the abandonment of classification of generalized epilepsy and localization-related epilepsy. We know that such a classification is far from perfect; and we might have numerous reasons to abandon it. However, generalized epilepsy, such as childhood absence epilepsy (CAE), does exist; so does localization-related epilepsy like temporal lobe epilepsy, although they may represent extremes. The problems usually arise from two aspects. First, there are many types of epilepsy (or syndromes, patients clinically) have both generalized seizures and focal seizures, how to define epilepsies of such? Secondly, how to define the significance of each seizure type in classification of epilepsy? For instance, absence is the characteristic generalized seizure for CAE; whereas GTCS is not specific, which may occur in any patients with any types of epilepsy; and myoclonic seizures have a varied significance in diagnosis of different epilepsies. Further effort should be put on such aspects.

3. On the organization. Personally I am against "a flexible, multidimensional manner as appropriate for the specific purpose". However, from the point of the commission, there should be a recommended, relatively stable, and easily accessible organization for the classification. Since the complexity in seizure type and epilepsy type, a relatively fixed organization is necessary, for most of the doctors to get into the classification and epileptology. Just like a library, we can update the books, but not necessary to change the location of the bookshelf frequently. In such an organization, two to three dimensions may be acceptable; whereas multidimensional manner be

used for the specific purpose. As stated above, a dimension of generalized epilepsy and localization-related epilepsy seems practical, as long as the dichotomy of “focal” and “generalized” exists. Since it is usually a beginning point for clinical practice, as well as for teaching or study.

4. The writing. It is not my privilege to talk on writing. I know that all authors use perfect native English. But most of the readers would probably not native English speakers. I wonder whether some sentences could be expressed in a more direct way. For instance, “The result was a veneer of equivalency bestowed upon all epilepsy entities identified within the document” in page 7, means “this may lead to the misunderstanding that all syndromes listed in the classification have equal significance in diagnosis”? and the sentence before this seems too long; “constellations” seems not a popular medical word.

5. Specific points:

a. For the ***“Underlying type of cause (etiology).*** *Underlying causes will be grouped as: Genetic, Structural/Metabolic, and Unknown”.*

How about using “Acquired” to replace “Structural/Metabolic”? As stated later, “Structural/Metabolic” disorders, such as “tuberous sclerosis and many malformations of cortical development”, may also be of genetic origin. It thus seems not so good. It is difficult, sometimes, to define the distinction “that there is a separate disorder that appears to be interposed between the genetic defect and the epilepsy”. For instance, FCD may vary greatly in its extent and degree. Considering such factors, it seems reasonable to classify “Genetic” further into “that with structural abnormalities” and “that without apparent structural abnormalities”.

b. “replaces the term secondarily generalized seizure” in the last of Table 2. Use what term to replace “the term secondarily generalized seizure”? A simple and precise term is always important.

c. “Febrile seizures plus (FS+)” in Table 3. How about “Epilepsy with febrile seizures plus”? Traditionally, the term FS+ was used to denoted patients presenting with FS outside the 6 ages range, and/or with afebrile GTCS, but not include those with other types of seizure. When “Epilepsy” was used, it might be of any seizure type; and antecedent FS was one of its features.

d. “**Less Specific Age Relationship *”** in Table 3 should not be a heading equal to “**Electro-clinical syndromes**” or “**Distinctive Constellations**”. Should it be a subheading of “**Electro-clinical syndromes**”?

e. The headings of first level, i.e. “**Electro-clinical syndromes**”, (“**Less Specific Age Relationship *”),** “**Distinctive Constellations**”, “**Epilepsies attributed to and organized by structural-metabolic causes”, “Epilepsies of unknown cause” …,** is along with a mixed axis of “distinctive” and causes. It seems a little confusing. Some

syndromes in the first class, such as West syndrome and Lennox-Gastaut Syndrome, may be of known or unknown causes.

Again, I want to say it is real a hard work. I appreciate the work of all authors.

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