

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

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The Commission is to be thanked for what must have been a huge amount of work. No piece of work of this nature is going to find universal agreement. Indeed it is probably inevitable that it will provoke argument. The comments below address what I consider to be important problems with the Report as it stands. I hope at least some of them will be addressed before the final version of the Report is published.

1. I find the arguments advanced for abandoning the concept of 'focal' and 'generalised' epilepsy syndromes unconvincing. It is clear that not all epilepsy syndromes can be classified in this way, but many can (in the sense that many of the best characterised syndromes are characterised by only focal or only generalised seizures). Recognising this has important therapeutic implications. Abandoning such a useful concept might well have adverse consequences on patient care. I suggest that the recommendation should be that syndromes can appropriately continue to be classified as being focal or generalised but it should be stressed that many epilepsy syndromes cannot be so classified and that there are other equally valid ways in which to 'organize' syndromes in the flexible, multidimensional manner proposed.
2. The suggestion of classifying by only three main aetiological groups (genetic, structural/metabolic, and unknown) is unconvincing.
 - a. In the first place what exactly is meant by 'genetic' is not clearly defined. Excluding for the moment those 'genetic epilepsies' in which a structural lesion or metabolic problem is interposed between the genetic defect and the epilepsy, is the term supposed to imply that the epilepsy has been proven (beyond doubt? or is some lower standard of proof acceptable) to be a consequence of a single genetic defect or will epilepsies shown to be / suspected of being polygenetic in origin be included here. I strongly suspect that, even amongst experts, there would be scant agreement as to what epilepsies should be considered genetic according to the Commissions Report. For example, it seems to be the case that CAE is to be considered genetic but that BECTS and Panayiotopoulos syndrome are listed as being of unknown aetiology. The evidence for this is not very strong and somewhat controversial – surely not a good basis for a classification. At the present time it would seem to me that we have strong evidence that certain epilepsies are a consequence of genetic disorders giving rise to channelopathies, receptor defects, etc. It would be better to classify these as channelopathies and receptor defects, etc than the notionally attractive but imprecise term 'genetic epilepsy'. A few further reflections on how difficult it might be to use the genetic category. Does the child with Down syndrome with spasms have a genetic epilepsy or is there some

unknown structural defect interposed between the genetic defect and the epilepsy? What about the child with NF1 who develops occasional focal seizures. I know what I think would be a sensible answer but having read the Report, I am not sure if I am correct!

- b. Why combine structural and metabolic – they are so different. I think they should be separated.
3. The justification for introducing the new term ‘constellation’ is not made. The Commission does not explain why the ‘constellations’ they list can not reasonably be considered electroclinical syndromes or, in the case of mesial temporal lobe epilepsy, even a disease (a medical term which seems strangely to have been abandoned).
4. The Commission suggests abandoning the category of unclassified seizure. Why? Is it suggesting that all seizures can be classified by any reasonably competent clinician (if so, perhaps I need to look for a new job). Surely the unintended consequence of this will be that people will feel forced to classify seizures without sufficient knowledge to do so and will make errors.
5. The inclusion of epileptic spasms as a seizure type which can be focal, generalised, or unclear is to be welcomed. However, the same can be said of the other seizures listed as generalised. In other words, tonic, clonic, myoclonic and atonic seizures can be generalised or focal seizure types as well. Unless this is made clear, this may cause a lot of confusion. Perhaps, the commission should recommend that when the terms tonic, clonic, myoclonic, atonic and epileptic spasms are used to designate a particular seizure type it should be stated whether the seizure is focal, generalised or unknown.
6. In table 2 the re-introduction (compared to the 2001 diagnostic scheme) of the term ‘impairment of consciousness’ will no doubt be welcomed by many clinicians as pragmatic. Nevertheless, given the strong arguments against the use of this term in the 2001 diagnostic scheme, I think a discussion is required outlining how this *volt face* has come about.
7. In the list of electro-clinical syndromes (Table 3) the continued use of the terms ‘early onset benign childhood occipital epilepsy (Panayiotopoulos type)’ and late onset childhood occipital epilepsy (Gastaut type)’ is illogical. These were names given relatively early on in the development of the concept of these syndromes. Since then many independent research teams have published on ‘early onset benign childhood occipital epilepsy (Panayiotopoulos type)’ and virtually all agree that it is inappropriate to consider it as an occipital epilepsy. An international consortium of researchers reviewed this in detail. I do not intend to go over all the evidence – surely all that is required is to point out that a number of published ictal EEGs of seizures in Panayiotopoulos syndrome demonstrate onset in sites other than the occipital lobes. It is surely unscientific for the Commission to continue to use the outdated term ‘early onset benign childhood occipital epilepsy (Panayiotopoulos type)’. Panayiotopoulos syndrome is now the term mostly used in scientific publications and is in common clinical use

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