

Roger J. Porter Comments—3Sep09 (From an old reactionary!)

Summary of Changes in Terminology and Concepts:

1. Mode of seizure onset and Classification of Seizures (Table 1): Could not find any tables in the e-mail

Generalized epileptic seizures are now considered to originate at some point within, and rapidly engage, bilaterally distributed networks. Such bilateral networks can include cortical and subcortical structures, but do not necessarily include the entire cortex. Although individual seizure onsets can appear localized, the location and lateralization are not consistent from one seizure to another. Generalized seizures can be asymmetric. GOOD

Focal epileptic seizures are now considered to originate within networks limited to one hemisphere, which may be discretely localized or more widely distributed. Focal seizures may originate in subcortical structures. For each seizure type, ictal onset is consistent from one seizure to another with preferential propagation patterns, which can involve the contralateral hemisphere. In some cases, however, there is more than one epileptogenic network, and more than one seizure type (confusing—do you mean SP->CP->GTC? or do you really mean something radical like a partial and a generalized seizure all at the same time), but each individual seizure type has a consistent site of onset. Focal seizures do not fall into any recognized set of natural classes based on any current understanding of the mechanisms involved.

UP to this point you are talking about seizures. Next you are talk about syndromes and the epilepsies. Don't you think you should make this distinction clear? Also unclear—at this point-- is how the above comments will actually affect the seizure classification.

In a departure from the 1989 classification scheme, syndromes will no longer be characterized as being generalized or focal ("localization-related"). So how will they be divided? Why leave the audience wondering? And what happened to "partial"?—I don't like it either, but we should give a reason for getting rid of it. After all, partial was used instead of focal for some good reasons which you document very well in the above description.

2. Syndrome versus epilepsy:

The 1989 report used the terms "syndromes" and "epilepsies" almost interchangeably. Henceforth, the use of the term "syndrome" will be restricted to a group of clinical entities that are reliably identified by a cluster of electro-clinical characteristics. Patients whose epilepsy does not fit the criteria for a specific electro-clinical syndrome can be described with respect to a variety of clinically relevant factors (e.g. known etiology, seizure types, etc). This does not, however, provide a precise (syndromic) diagnosis of their epilepsy. GOOD, but then what is an "epilepsy"? I don't think you can carefully define syndrome and ignore epilepsy.

3. Underlying type of cause (etiology)—talking syndromes here, not seizure types —could be very confusing to the novice

Underlying causes will be grouped as:

- Genetic
- Structural/Metabolic
- Unknown

These terms are defined in the accompanying text. They do not entirely correspond to and should not be interpreted as simple substitutions for the older ones—what does that mean? This is not a clarification, it is an obfuscation.

4. Organization:

In the 1989 publication, syndromes were organized primarily according to "mode" of expression (localization-related versus generalized) and underlying cause (idiopathic, symptomatic, and cryptogenic). We recommend that this approach to classification be abandoned and that, in preparation for the paradigmatic shift in classification, which will be forthcoming (but painfully slowly for many epilepsies), we organize our knowledge regarding syndromes and epilepsies in a flexible, multidimensional manner as appropriate for the specific purpose. An organizational structure which first emphasizes cause, age at onset or virtually any feature (e.g. known channelopathy, specific EEG features, specific types of MRI findings) can thus be constructed.

Explanatory Notes

The previous "classifications" of seizures and epilepsies were often treated as rigid doctrine. This simplified efforts to teach concepts of epilepsy and to perform therapeutic trials. Advances in all areas of investigation (epidemiology, electrophysiology, imaging, developmental neurobiology, genetics, systems neurophysiology, and neurochemistry) have made it clear, however, that such a simple approach does not do justice to the complexity of the underlying developmental and physiological processes. Therefore any classifications put forth by this Commission should be viewed as a guide to summarize our current understanding about seizures and epilepsies in a useful manner, one that is responsive to the needs to which it is put as well as flexible enough to incorporate new information as it develops. The full significance of this will not be apparent until the anticipated new approaches to classification are fully developed. In the interim, we encourage people to begin conceptualizing a future classification as a flexible, multidimensional catalog of essential key features that can be used for organizing information about different forms of epilepsy (or seizures) as appropriate for the purposes of clinical practice, antiepileptic drug development as well as clinical and basic research. It will, in essence, be a database. In the future, those and other essential pieces of information will form the basis for developing a diagnostic manual. The following presents the changes in current conceptualization, terminology, and definitions with the rationales behind these changes. Good scientific summary, but largely about our ignorance.

I. Mode of seizure onset and Classification of Seizures:

The terms 'focal' and 'generalized' have been used to express a dichotomous classification for both seizures and the epilepsies. For seizures, based on current electro-clinical evidence, such a dichotomy remains useful. However, for epilepsies, recent electro-clinical, imaging and genetic data do not support such a simple dichotomy. OK

According to current knowledge all epileptic seizures involve neuronal networks, which can be relatively localized (and can stay that way or can spread), more widely distributed, limited to one hemisphere, or bilateral (Are you talking about the origin of the discharge or its ultimate distribution in a single seizure?—not clear). These networks often involve both cortical and subcortical structures. Consequently, the terms 'focal' and 'generalized' need to be clarified to reflect the current underlying pathophysiology and anatomical substrates of ictal events:

In referring to seizures, focal indicates that the seizures originate primarily within networks limited to one cerebral hemisphere. These may be discretely localized or more widely distributed ([hence the old term "partial" which I do not think you can ignore](#)). Some lesions in subcortical structures may produce focal seizures (e.g. hypothalamic hamartomas). For each seizure type, ictal onset is ([may be](#)) consistent from one seizure to another with preferential propagation patterns, which can involve the contralateral hemisphere. In some cases, however, there is more than one epileptogenic network, and more than one seizure type, but each individual seizure type has a consistent site of onset ([this suggests that a single focus is limited to a single seizure manifestation: if you include spread as a variable, this is simply not true](#)). This also applies to cases in which focal seizures may arise independently in either hemisphere (eg bilateral mesial temporal lobe epilepsy or benign epilepsy with central temporal spikes (BECTS)).

Generalized epileptic seizures originate within ([how do you know that some generalized seizures do not have a unilateral onset that you simply cannot see? I think this is an unwarranted assumption](#)), and rapidly engage, bilaterally distributed networks. Such bilateral networks can include cortical and subcortical structures, but do not necessarily include the entire cortex. Although individual seizure onsets can appear localized, the location and lateralization are not consistent from one seizure to another ([Not sure I know what this means](#)). Generalized seizures can be asymmetric. [—for sure!](#)

In addition, the following specific changes to the 1981 classification of seizures have been made.

- Neonatal seizures are no longer regarded as a separate entity. Seizures in neonates can be classified within the proposed scheme below.
- The previous subclassification of absence seizures has been simplified and altered. Myoclonic absence seizures and eyelid myoclonia are now recognized. [—automatisms???—tonia???—see paper by Penry et al in Brain, 1975.](#)
- Epileptic spasms are now included in their own category as seizures which may be generalized, focal, or of unclear onset. [It took me a minute to realize that you are talking about infantile spasms. Could you not say that you are abandoning this term—if you dare](#)
- Under focal seizures the distinction between the different types (e.g. complex partial and simple partial) is eliminated. It is important however to recognize that impairment of awareness or other dyscognitive features, localization, and progression of ictal events can be of primary importance in the evaluation of individual patients and for specific purposes (e.g. randomized trials, surgery). Nothing in this recommendation precludes describing focal seizures according to these features (see further below). [—then what is the logic of destroying the partial seizure dichotomy which has served us so well?](#)
- Myoclonic atonic (sometimes referred to as myoclonic astatic) seizures are now recognized [—atonic and astatic seizures are different and we need to say so](#)
- The category of unclassified epileptic seizures has been eliminated [—a great testament to our sophisticated level of knowledge](#)

The list of recognized generalized seizures may be found in **Table 1**. [—could not find any tables](#)

Descriptors of focal seizures The 1981 seizure document used the terms simple partial, complex partial and partial seizures secondarily generalized. This terminology was imprecise as the terms "simple" and "complex" were often misused or misunderstood. Moreover, the distinction based on impairment of consciousness, although of great pragmatic social importance (eg for driving competence), was impossible to define in a precise scientific manner (Gloor 1986). The term "secondarily" generalized is poorly understood and inconsistently used. At the present time, we do not have the necessary information to create a scientific classification within focal seizures. Regardless, for pragmatic reasons and to facilitate continuity with the 1981 classification of seizures, descriptors of focal seizures may be used, individually or in combination with other features depending on the purpose. For example, in certain circumstances such as pre-surgical evaluation it may be useful to have the sequence of specific elemental features of seizures described (Blume WT et al., 2005, Luders et al., 1993). We have listed descriptors chosen to facilitate continuity with the 1981 seizure document (**Table 2**). We emphasize, however, that these descriptors do not represent natural classes and are not a "classification" as such. [Nonsense. Any effort to classify, based on any criteria thought to be useful, is a genuine classification. It may not be any good, but it is still a classification. This paragraph is a waffle to try to discredit the success of the current empirical classification without putting forward a more useful effort.](#)

II Syndromes and Epilepsies:

The 1989 proposal incorporated all forms of epilepsy into an all-encompassing organizational system. The result of this inclusiveness was that the term "syndrome" took on a broad and very imprecise meaning to the point where very specific and highly recognizable entities (such as childhood absence epilepsy) and poorly differentiated and not well described epilepsies (such as cryptogenic parietal lobe epilepsy) tended to be treated as though they represented the same level of diagnostic precision. The result was a veneer of equivalency bestowed upon all epilepsy entities identified within the document. An important revision therefore entails explicitly acknowledging the different levels of specificity and cohesiveness among the various entities that represent different epilepsy diagnoses. [OK](#)

Disease versus syndrome: Although there is reason to distinguish the concepts of disease and syndrome, these terms are not consistently used in medicine. Ultimately, it was decided not to insist on the disease-syndrome distinction in referring to the epilepsies at this time, although either or both terms may be used depending on the context and custom. Instead, there are at least four groupings that may be invoked in this context and as described below:

Electroclinical syndromes: An electroclinical syndrome is a complex of clinical features, signs and symptoms that together define a distinctive, recognizable clinical disorder. These often become the focus of treatment trials as well as of genetic, neuropsychological, and neuroimaging investigations (e.g. Guerrini R et al., 2007, Ottman et al., 2008, Scheffer IE et al., 1998, Scheffer IE et al., 2008)).

Use of the term "syndrome," and more precisely "electro-clinical syndrome," will be restricted to a group of clinical entities that are reliably identified by a cluster of electro-clinical and developmental characteristics. These are largely but not exclusively genetic in origin, and tend to have a strong relationship to developmental aspects of the brain. These are distinctive disorders identifiable on the basis of a typical age onset, specific EEG characteristics, seizure types, and often other features which, when taken together, permit a specific diagnosis. The diagnosis in turn often has implications for treatment, management, and prognosis. The term for these entities is "*Electro-clinical Syndromes*." While ultimately common usage will likely shorten the term again to "syndrome" alone, this is still specifically defined to mean entities that can be considered *electro-clinical syndromes*. It would be inappropriate to refer to, for example, epilepsy with a frontal lobe focus and not otherwise specified as a "syndrome." The currently recognized electro-clinical syndromes are presented in the first part of Table 3 organized by typical age at onset as this is one of the most distinctive and clinically salient dimensions for organizing these entities.

Constellations: In addition to these electro-clinical syndromes, there are a number of entities that are not recognized as electro-clinical syndromes *per se* but which represent clinically distinctive *constellations* on the basis of specific lesions or other causes. These are diagnostically meaningful forms of epilepsy and may have implications for clinical treatment, particularly surgery. Chief among these are Mesial Temporal Lobe Epilepsy (with hippocampal

sclerosis), hypothalamic hamartoma with gelastic seizures, and Rasmussen "syndrome." Age at presentation is not a defining feature in these disorders, as we understand them.

Epilepsies secondary to specific structural or metabolic lesions or conditions: The next group includes epilepsies secondary to specific *structural or metabolic lesions or conditions* but which do not, given our current understanding, fit a specific electro-clinical pattern, although that may change in the future. Therefore, these entities represent a lower level of specificity than the two previous groups. In the past, many such epilepsies were grouped together as "symptomatic focal epilepsies" and largely distinguished on the basis of localization. In the revised classification, we recommend that less emphasis be given to localization and more to the underlying structural or metabolic cause. Consequently, terms such as "symptomatic temporal lobe epilepsy" are replaced by longer but more precise expressions such as "epilepsy with focal seizures secondary to focal cortical dysplasia in the temporal lobe." Localization may be considered but is not, based on our current knowledge, the primary factor of importance for understanding the cause and prognosis of the epilepsy. These epilepsies are now included in the over-arching etiological grouping of "*Structural /metabolic epilepsies*." (see below)

Epilepsies of unknown cause: What remains are those epilepsies which in the past were termed "cryptogenic," including those that were considered "undetermined." These epilepsies account for a third or more of all people with epilepsy, are the most poorly understood and represent perhaps the most fertile area for future research in imaging and genetics. For such research to be feasible, however, it will require that the simple characterization by localization of inter-ictal spike (e.g. cryptogenic parietal lobe epilepsy) be replaced with a detailed characterization of all relevant features (e.g. age at onset, specific EEG features, cognitive and developmental assessments, diurnal patterns of seizure occurrence, etc). Among these poorly differentiated epilepsies are likely to be additional genetic electroclinical syndromes; however, they cannot be recognized until they are adequately characterized. Autosomal dominant nocturnal frontal lobe epilepsy (ADNFLE) and autosomal dominant partial epilepsy with auditory features (ADPEAF) are examples of specific electro-clinical syndromes which were discovered within these poorly differentiated epilepsies (Ottman R et al., 1999, Scheffer et al., 1995). This approach will also facilitate identification of non-genetic determinants of epilepsy. The label for this group in which no cause has yet been identified is "*epilepsies of unknown cause*."

Table 3 provides a list of entities according to their level of specificity and within those designations, by age at onset where meaningful. [Sure would like to see these tables](#)

Note that in referring to syndromes the dichotomy of focal versus generalized will be abandoned, ie. "the focal or generalized epilepsies." Instead epilepsies will be referred to according to the etiological designation and further as characterized by seizures of generalized or focal onset or both. This is meant to separate the manifestations from the pathophysiology.

III. Etiological Designation:

The terms idiopathic, symptomatic, and cryptogenic have taken on a variety of meanings and connotations laden with presumptions which, at times, conflate multiple concepts into a single word. This has resulted in considerable contradiction and confusion. The term idiopathic was defined in the 1989 document: "*There is no underlying cause other than a possible hereditary predisposition. Idiopathic epilepsies are defined by age-related onset, clinical and electrographic characteristics, and a presumed genetic etiology.*" The term, however, is also used to convey the idea of a highly pharmaco-responsive form of epilepsy. Many, although not all, of the traditional "idiopathic" epilepsies also spontaneously remit during a predictable age range (a separate quality or dimension) and were generally thought to be unaccompanied by other consequences or disabilities, although this is clearly not the case as a variety of subtle cognitive and behavioral disorders are seen in association with these forms of epilepsies.

The term "symptomatic" is a truism as all epilepsy is symptomatic of something. It is often substituted for the concept of a poor prognosis for seizure control. Finally, "cryptogenic" was defined in 1989 as meaning "presumed symptomatic" apparently in the sense of "lesional." It is, however, from among these "cryptogenic" epilepsies that syndromes such as ADNFLE and ADPEAF have been discovered. The Commission has abandoned all three terms and redefined concepts for groups of underlying cause.

The following three groups for causes are recognized: [OK](#)

1. **Genetic.**
The concept of genetic epilepsy is that *the epilepsy is, as best as understood, the direct result of a known or presumed genetic defect(s) in which seizures are the core symptom of the disorder.* The knowledge regarding the genetic contributions may derive from specific molecular genetic studies that have been well replicated and even become the basis of diagnostic tests (e.g. *SCN1A* and Dravet syndrome) or the central role of a genetic component may rely on evidence from appropriately designed family studies. Designation of the fundamental nature of the disorder as being genetic does **not** exclude the possibility that environmental factors (outside the individual) may contribute to the expression of disease. At the present time, there is virtually no knowledge to support specific environmental influences as causes of or contributors to these forms of epilepsy. Examples of epilepsy syndromes that would be classified as genetic epilepsies include childhood absence epilepsy, autosomal dominant nocturnal frontal lobe epilepsy, and Dravet syndrome. Note that in the 1989 classification, Dravet syndrome was not classified as idiopathic epilepsy. It will now be considered as a genetic epilepsy. In doing this, we are requiring the concept of cause to contain only one dimension and not include multiple factors such as treatment response, likelihood of spontaneous remission, or severity of consequences and co-morbid conditions. Cause is no longer equated with prognosis, and the implication that "idiopathic" implies "benign" is intentionally discarded. It is possible that the genetic defect may have other effects in addition to the seizures but, as best we can tell, these other effects are not interposed between the genetic effect and the seizures.
2. **"Structural/metabolic."** The concept of a grouping together structural and metabolic causes of epilepsy is that there is a distinct other condition or disease that has been demonstrated to be associated with a substantially increased risk of developing epilepsy in appropriately designed studies. Structural lesions of course include acquired disorders such as stroke, trauma, and infection. They may, however, also be of genetic origin (e.g. tuberous sclerosis, many malformations of cortical development). The distinction is that there is a separate disorder that appears to be interposed between the genetic defect and the epilepsy.

The Commission acknowledges that as new genetic contributions to epilepsy are recognized, it may often be difficult to know how best to characterize them with respect to the distinctions above. For example, *ARX*, a homeobox gene, is associated with phenotypic heterogeneity including West syndrome and lissencephaly (Stromme et al, 2002). *STXBP1* encodes a protein involved in synaptic vesicle release and is associated with Ohtahara syndrome (Saito et al., 2008). Both syndromes involve severe encephalopathic forms of epilepsy. In the first case, one might conceivably consider the *ARX* mutation in the structural/metabolic category. In the case of *STXBP1*, because of the function of the protein product, one might possibly associate this with the concept of genetic epilepsy. No determination has been made in either case at this time. Instead the role of the specific genetic error should be recognized but it is not necessary to pigeon-hole the cause of the disorder further unless there is an adequate basis for doing so. We advocate a focus on mechanisms. This focus will ultimately reveal the natural classes. The overly simplistic designation of "genetic" versus "structural-metabolic" will then be replaced by a more precise characterization of the underlying cause. Groups and names for groups of causes should ultimately reflect natural classes.

3. **"Unknown cause."** Unknown is meant to be taken neutrally and to designate that the nature of the underlying cause is as yet unknown, it may have a fundamental genetic defect at its core or it may be the consequence of a separate disorder or condition not yet recognized. Examples of syndromes that would be classified as "of unknown cause" include migrating partial seizures of infancy and myoclonic epilepsy in infancy (formerly benign myoclonic epilepsy of infancy, (Engel J, 2006)). At the present time, it might be reasonable to include some of the traditional "idiopathic" electro-clinical syndromes in this category as well. These include benign rolandic epilepsy (Vadlamudi L. et al., 2006)

and the benign occipital epilepsies of childhood, both Panayiotopoulos and Gastaut types (Taylor I, et al., 2008). It is likely that genetic factors are involved in these syndromes but present evidence (e.g. low or absent concordance in siblings) does not suggest that genetic factors are paramount.

Certain electro-clinical syndromes, such as infantile spasms, may have multiple different causes. This should be acknowledged when describing the syndrome in general, and the specific cause should be identified for the individual patient.

IV. Other dimensions for classifying epilepsies and organizing information:

In addition to the traditional dimensions and features, each syndrome and each patient can be characterized according to a large number of other features which are often routinely part of any patient's evaluation and which are essential features in distinguishing among established syndromes. These include the cognitive and developmental antecedents and consequences, motor and sensory exam, EEG features, provoking or triggering factors, patterns of seizure occurrence with respect to sleep. In addition, there are two traditional clusters of syndromes which, for the present, are convenient to maintain, "idiopathic generalized epilepsy syndromes" and "idiopathic focal epilepsy syndromes." The significance and validity of these groupings may be upheld or ultimately rejected in time. The use of the term "idiopathic" in this context is anachronistic and vestigial much as is the expression "to dial" a phone number is used in most parts of the world today.

IV- A. Age at onset:

For the purposes of grouping syndromes or individuals, age at onset categories are recommended as per standard use: neonate (<44 weeks gestational age), infant (<2 years), child (2-12 years), adolescent (12-18 years), and adult (>18 years). The age ranges are approximate and meant to be used only for convenience in describing already characterized forms of epilepsy. For individual patients, the exact age at onset or best approximation should be used, and greater precision for syndromes is encouraged when possible.

IV- B. Natural evolution:

Many terms have crept into usage to describe the natural course and consequences of epilepsy. These terms include "epileptic encephalopathy" and "benign."

1. **Epileptic encephalopathy.** The concept of epileptic encephalopathy embodies the notion that the epileptic activity itself may contribute to severe cognitive and behavioral impairments above and beyond what might be expected from the underlying pathology (e.g. cortical malformation) alone, and that these can worsen over time. Inherent in this concept is the idea that by suppressing or preventing the epileptic activity, one may improve the cognitive and behavioral outlook of the disorder. In the developing brain, this concept has led to the hope that rapid effective intervention should and can be used before the abnormal epileptic activity interferes irrevocably with normal processes of brain development. Recent studies in children from the surgical and pharmacological literature (Freitag H and Tuxhorn I, 2005, Jonas R et al., 2005, Jonas R et al., 2004, Lux AL et al., 2005) tend to support this concept. Epileptic encephalopathy can present along a continuum of severity and may occur at any age. The phenomenon is most common and severe in infancy and early childhood where global and profound cognitive impairment may occur. Adults, however, can also suffer cognitive losses over time from uncontrolled seizures (Hermann B., et al. 2006).

The term "epileptic encephalopathy" can be used to characterize syndromes as well as be applied to individuals. As a *domain for clustering and describing syndromes*, an epileptic encephalopathy is an electro-clinical syndrome associated with a very high probability that the individual will develop encephalopathic features that present or worsen after the onset of epilepsy. Separately but important to note, as a group they tend to be very pharmaco-resistant but this is another quality or dimension. The best known and most common of these are West, Lennox-Gastaut, Dravet, Landau-Kleffner-CSWS, and Doose syndromes. Inclusion of a specific syndrome in the domain of "epileptic encephalopathy" does not imply that all individuals with these disorders will appear encephalopathic; however the risk is typically quite high. Recognition of this risk is a primary motivation for creating this domain as early effective intervention including surgery may improve seizure control and developmental outcome in some cases.

Diagnosing an individual as having an encephalopathic course requires demonstration of a failure to develop as expected relative to same-aged peers or to regress in abilities. Note that it is not necessary for an individual to have a syndrome identified as being one of the "epileptic encephalopathies" in order to have an encephalopathic course.

"Epileptic encephalopathy" should be viewed as a concept and a description of what is observed clinically with the recognition that, we are rapidly approaching a clearer understanding of the effects of seizures on brain function and their potential for lasting deleterious impact in the developing brain. At the same time, however, we must recognize that the source of an apparent encephalopathy is usually unknown. It may be the product of the underlying cause, the result of epileptic activity, or a combination of both.

2. **"Benign":**

The names of many syndromes contain the word "benign."

Two key features of "benign" epilepsy syndromes are that they:

- a. Involve seizures which are self-limited in that spontaneous remission, regardless of treatment, occurs at an expected age and is the anticipated outcome in the vast majority of cases,
- b. The consequences, if any, of the seizures are generally not disabling over the course of the active seizure disorder. This does not preclude an increased risk of subtle to moderate cognitive and behavioral disorders prior to, during, or extending beyond the active phase of the seizures.

With our increasing awareness, however, of the cognitive and behavioral comorbidities, psychiatric disorders, migraine, and even sudden death that may accompany any form of epilepsy, the term "benign" itself seems inappropriate as it may lead to false hopes and unrealistic expectations.

As did the term "idiopathic," "benign" blends together different qualities which, individually, may pertain to other epilepsies that are not considered "benign." Consequently, we recommend that, instead of designating a group of syndromes as "benign," we recognize the different qualities that make up the concept of benign and apply them specifically and consistently to individual forms of epilepsy. While predictable spontaneous remission is a desirable quality, it should be identified as "self-limited" electro-clinical syndromes, that is, electro-clinical syndromes that have a high or moderately likelihood of spontaneously remitting at a predictable age.

Another feature that is also seen in these self-limited syndromes is that they are also very pharmaco-responsive. This is true of other syndromes that are not always as self-limited such as CAE and JME. Diagnosis of one of these syndromes allows, within a reasonable certainty, the prediction that the seizures will rapidly come under control with appropriate medication. In fact, this is one of the common features of the groups of syndromes previously labeled "Idiopathic." Diagnosis of one of these electro-clinical syndromes is of key importance for family and patient counseling. Labeling these syndromes as pharmaco-responsive is likely more meaningful to clinicians and families than the term "idiopathic" which contains other implications which may or may not apply to a given electroclinical syndrome.

Of note, the inclusion of features that are descriptive of the natural evolution of a form of epilepsy is not, strictly speaking based upon natural classes but rather on repeated observations and impressions. They are included for pragmatic purposes.

IV-C. Other features:

Many other dimensions and features will ultimately be used in describing, classifying, and grouping the different forms of epilepsies. Depending on the purpose, these other features may be more useful in grouping and organizing syndromes and forms of epilepsy than are the primary ones with which most of us are familiar. Dimensions would include but are not limited to detailed aspects of ictal and interictal EEG, structural neuroimaging findings, neurological exam, cognitive and psychiatric status

An interim organization ("classification") of the epilepsies:

In a departure from the 1989 classification of the epilepsies, there is no one specific organization proposed for the revised classification. Instead, the various forms of epilepsy (at all levels of specificity) will be organized according to whichever dimensions are most relevant to a specific purpose. These may be essentially the same dimensions used in the 1989 classification (mode of seizure onset, "etiology" and age at onset) a different hierarchical arrangement of these same dimensions, a more detailed version of these dimensions, or by an entirely different set of dimensions, as appropriate to the purpose. For example, rather than a simple dichotomy of epilepsies based on association with focal versus generalized onset seizures, epilepsies can be organized by specific seizure type. The advantages of this from the perspective of a future diagnostic manual are considerable. Epilepsies could also be organized by specific cause, e.g. ion channelopathies and within that category, specific ion channel genes, as is being done with prolonged QT syndrome (Johnson et al., 2008). By the same token one could organize a subgroup of epilepsies according to age at onset and association with *specific* types of malformations of cortical development (e.g. see Lerner et al. 2009).

The benefits of this approach become increasingly clear as one considers the differences between characterizing and classifying syndromes versus individual patients. A syndrome is characterized with respect to a host of factors. If one knows a given patient's syndromic diagnosis, one knows a considerable amount about that patient's epilepsy, e.g. likely age at onset, EEG patterns, likely responses to medications, cognitive and developmental status, and so forth. We can organize our information about these syndromes along the many dimensions by which they are characterized. For those epilepsies that do not fall into clear electro-clinical syndromes and which are associated with structural-metabolic causes, the most natural and rational primary approach to classifying or organizing them is by the specific underlying cause or lesion. For those epilepsies of unknown cause and that are predominately characterized by mode of seizure onset, there is no natural class that conveniently and validly sorts them into more homogeneous groups. The revised recommended approach explicitly acknowledges this. Forcing these partially or poorly characterized epilepsies into a system of classification for which they are not yet ready suggests greater knowledge than we currently have and serves to impede progress. Much greater effort should be invested, both in the clinic and in clinical research, into characterizing individual patients in sufficient detail according to such a set of dimensions and in such a way as to facilitate objective research into identifying previously unrecognized constellations and syndromes. This information can then be used as the basis for objective analyses to identify potential new "syndromes" Berg and Blackstone, 2006). It will also greatly facilitate the use of the planned diagnostic manual which will provide a guide with specific definitions and examples that will encourage clinicians to make the necessary observations on all patients in order to make or exclude specific diagnoses.

This report updates the current terminology and concepts in classification of epilepsy until a completely different set of methods can be put in place. The plans for that process will be described in detail separately. For the new approach to be successful, however, broad consensus and input from the epilepsy community will be required at each step of the way. We encourage all those to whom this is of interest carefully to consider the issues raised above, to follow future announcements and reports, and to participate in the discussions to ensue. For now, we remind everyone that (1) any classification approach should be viewed as summarizing our current level of knowledge and not as a rigid, final document and (2) the classification maintain its primary clinical value for understanding, diagnosing, and treating epilepsy. Finally, in terms of impact on the clinical use of the diagnostic entities that are listed in the previous ILAE statements, there is none. No changes have been made to the list of epilepsies, and the list of seizure types, while simplified, is not substantially different although we hope it will lead to less confusion and error in its application. In sum, we should all be as specific and precise as possible about each patient's type of epilepsy, seizures, and underlying cause.

Acknowledgements

Final Comment—I think this document is especially helpful with the revision of the epilepsies and syndromes. I find little merit in the arguments about seizure types and lots of misleading and confusing statements in those sections. The document moves back and forth between seizure types and syndromes in a most obtuse manner, which will surely confuse those who have not devoted a lifetime to these concepts.

I compliment the Commission on their hard work, knowing full well the agonizing effort that this document represents.

Roger