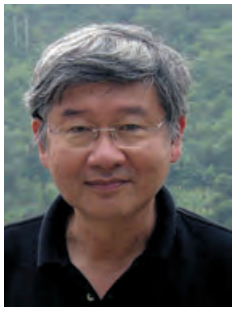
COMMENTARY: ILAE DEFINITION OF EPILEPSY



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The International League Against Epilepsy (ILAE) and the authors are to be congratulated for formulating the practical clinical definition of epilepsy,[1] which aims to make the previous conceptual definition[2] more clinically applicable. The process is particularly admirable, as it involved selected experts who created the initial draft, and the subsequent elaborate process, in which the epilepsy community at large globally was invited to contribute. Other than formulating the clinical definition of epilepsy, the authors also attempt to define epilepsy "resolved." Overall, I believe the document has achieved its mission admirably. Nevertheless, there are three comments.

First, the authors include reflex epilepsy in its new clinical definition of epilepsy. In the definition, each reflex seizure is given equal significance to unprovoked seizure, with epilepsy defined as at least two unprovoked (or reflex) seizures occurring more than 24 h apart. The reason given is that "even though the seizures are provoked, the tendency to respond repeatedly to such stimuli with seizures meets the conceptual definition of epilepsy, in that reflex epilepsies are associated with enduring abnormal predisposition to have such seizures."[1] Although during the many discussions on the definition of epilepsy, the core concept is often focused on "enduring alteration in the brain," I believe that the even more basic concept for the definition of epilepsy is "that increases the likelihood of future seizures."[2] The "enduring disposition" is theoretical; it is based on "increased likelihood of future seizures." The two concepts are closely related, the former based on the latter, and only the latter can be measured and quantified. When including reflex epilepsy as epilepsy, it is necessary to differentiate between seizures where the provoking factors are specific and avoidable, such as the photic "Pokémon" seizures, taking a hot bath, or playing chess and card games, from seizures for which provoking factors are difficult to avoid, such as speaking, reading, or calculations. Those with seizures caused by provoking factors that are difficult to avoid are likely to have "increased likelihood of future seizures," whereas those with avoidable provoking factors are not; both have "enduring alteration in the brain." Thus for reflex epilepsy, this author believes that the clinical definition should be an estimated future recurrent risk of seizures of at least 60%, with past history of recurrent seizures.

My second comment is related to the inclusion of epilepsy syndrome as epilepsy. The reason given by the authors is that "it makes little sense to say that someone has an epilepsy syndrome but not epilepsy." The authors further added that "epilepsy may be presumed to be present, even if the risk of subsequent seizures is low." Terminologies and names are language labels for representing concrete objects or abstract concepts. There may be varied and changing meaning to the same word. In medicine, some of names that are commonly used may even represent old and discarded concepts. For example, "hysteria" is related to uterus, and "myasthenia gravis" means "grave muscle weakness." Nevertheless, these widely accepted terms may still be retained, with the terms given new meaning. Thus what is primary is the concept, with the words used only a symbol. We should focus on the concept, and not be distracted by the symbol. The symbol can be modified later to better reflect the changing concept. Epilepsy syndrome is an extremely useful concept in epileptology, based on a group of electroclinical characteristics, which form an identifiable cluster. The word "epilepsy" carries slightly different meanings when used in the context of "syndrome," and in "clinical definition." In epilepsy syndrome, it is an adjective to identify the "syndrome," to indicate broadly the type of syndrome that is being referred to, whereas, in clinical definition, it is a noun, about the precise clinical meaning of epilepsy. The experts in the field of epilepsy syndrome should be free to determine what constitutes an identifiable cluster that can be called a syndrome; and what patients should be included in this syndrome; this may include patients who have only isolated seizures, or even without clinical seizure, thus acknowledging that some of the patients included in the said syndrome may not have "enduring alteration in the brain that increases the likelihood of future seizures," or epilepsy.

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On the other hand, when formulating what is clinical epilepsy, we should concentrate on working out its practical clinical meaning, which should be consistent with the concept of "enduring alteration in the brain that increases the likelihood of future seizures." We should not be loaded with carrying the total burden of epilepsy syndrome; the meaning of the term will certainly change with time.

Finally, in this document, the new term epilepsy "resolved" is being introduced. The term "resolved" is simple, already widely used in the common language, and is able to differentiate from other related words such as "cure" or "remission." However, it is not so easy to translate into some non-Caucasian–based languages (such as Chinese and Malay that I am familiar with), which may not have such a profuse number of vocabularies to choose from. I would prefer epilepsy in "remission," or "no longer present." Remission is already a commonly used term in medicine. The latter is descriptive and thus more clumsy, but easier to translate into other languages.

Disclosure

I have no conflicts of interest to disclose. I confirm that I have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

References

1. Fisher RS, Acevedo C, Arzimanoglou A, et al. A practical clinical definition of epilepsy. *Epilepsia* 2014;55:475–482.
2. Fisher RS, van Emde Boas W, Blume W, et al. Epileptic seizures and epilepsy: definitions proposed by the International League Against Epilepsy (ILAE) and the International Bureau for Epilepsy (IBE). *Epilepsia* 2005;46:470–472.