ENZYME-INDUCING AEDs SHOULD NOT BE USED AS FIRST-LINE AGENTS IN THE TREATMENT OF EPILEPSY (NO)

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This debate will focus on the idea that antiepileptic drugs (AEDs) that do not induce liver enzymes are safer and better than ones that do. Unfortunately there is no solid evidence to support this idea. The most common enzyme inducing AEDs are the cornerstone for the treatment of epilepsy, for example carbamazepine (CBZ) and phenytoin, which in Europe is used today preferably for status epilepticus. These AEDs have been shown to be effective and even recommended by the ILAE for the initial treatment of complex partial seizures. No drug that does not have an enzyme inducing effect has ever been shown to be superior to CBZ in evidence based Level 1 studies (see ILAE guidelines on www.ilae.com) concerning the variable of efficacy for new onset partial seizures. Because of their interaction potential with other drugs and hormones, drugs like CBZ have been demonized by some without strong supportive evidence but with the aid of retrospective case series or simple anecdotal reports. The few prospective studies that are available in the literature are without baseline information. Besides efficacy, in a randomized control trials CBZ- controlled release (CR) has not been shown to have a worse side effect profile than the comparative non-inducing AED levetiracetam (Neurology 2006). Topics as osteoporosis, teratogenicity, drug-drug interactions and side effects will be discussed. Using therapeutic drug monitoring (TDM), as has always been done, enzyme inducing AEDs can be successfully used even in the future as the mainstay or our therapeutic arsenal for epilepsy. In addition, enzyme inhibiting drugs like CBZ-CR are relatively inexpensive compared to the non-inducing drugs which are typically of a newer generation. To justify changing clinical practice while accruing increased cost for non-evidence based allegations about the inferiority of enzyme inducing AEDs is not justified.