DO PATIENTS WITH IDIOPATHIC GENERALIZED EPILEPSIES REQUIRE LIFELONG ANTI-SEIZURE DRUG TREATMENT? - YES

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Idiopathic generalized epilepsies (IGEs) constitute about one third of all epilepsies. They are presumed to be genetically determined and affect seemingly normal people of either gender and ethnicity. They express themselves with different seizure types- absences, myoclonic jerks, and generalized tonic-clonic seizures, alone or in varying combinations age of manifesting and severity. Status epilepticus may also occur. Most often these start in childhood or adolescence, but some have a later onset. They are usually lifelong, although a few are self-limiting. Treatment of IGEs is challenging for two main reasons. Firstly, some antiseizure drug (ASDs) are contraindicated. Secondly, efficacy of ASDs differs. Most respond well to appropriate ASDs, but treatment is often lifelong.

I will briefly be discussing about the different types of IGEs and treatment protocols. Parameters that premeditate recurrence include the risk of recurrence, the impact of recurrence on the quality of life of the patient, the type of epilepsy syndrome, the impact of discontinuing of ASDs on the psychosocial realm of the patient.

In adults: Most well done studies on ASD withdrawal have excluded generalized epilepsies and JME. Most of the studies on relapse on withdrawal of ASDs have a potential selection bias because they do not include patients with a higher risk of relapse, such as those with IGEs. It is hence difficult to answer this question.

In Children: In a Cochrane metaanalysis addressing the question of early versus late withdrawal of ASDs in patients in remission, the authors concluded that there was sufficient evidence to support waiting for at least two or more seizure free years before discontinuing ASDs in children, particularly if individuals have an abnormal EEG and partial seizures. Although there is insufficient evidence, as to the how to establish when to withdraw ASDs in children with generalized seizures this was not commented in the metaanalysis.

Emerging literature suggests that some patients even when having JME can undergo dosage reduction this is however an issue which needs careful one to one discussion with the patient and the caregiver taking into consideration facts about recurrence its harm, possibility of injuries/ SUDEP, driving, vocation, marriage and relationship issues.

An attempt to find certain predictors for outcomes in JME has also been done in patients followed up for 25 years or so. About a third of patients could be seizure free on AED withdrawal. Presence of Bilateral myoclonus preceding the GTCS and need for polytherapy were predictors for recurrence. These studies however have a small sample size.

As seizure recurrence rates are high and some of the IGEs have long age prevalence it would be prudent not to attempt ASD withdrawal in all. Tapering may be tried. More evidence needs to be gathered with prospective randomised design on withdrawal as the evidence as of now does not suffice.