

key points

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Epilepsy is the propensity of a person to have unprovoked

epileptic seizures because of an underlying neurological or somatic condition. Although the prevalence is highest during adolescence and early adulthood, the incidence is highest and rising in adults over 65. According to the International League Against Epilepsy, epilepsy can be diagnosed if any of the following criteria are met: at least two unprovoked seizures occurring on separate days (seizures within 24 hours count as one event); one unprovoked seizure with at least a 60% risk of recurrence over the next ten years on the basis of associated clinical factors (such as a recent stroke or brain tumour); diagnosis of a specific epilepsy syndrome.

For each paroxysmal episode it is important to establish

the sequence and progression of events, whether consciousness was impaired, and how much control the patient felt over the events. Convulsive events should be described rather than given a label. Witnesses may recall automatisms (e.g. orofacial or manual) and asymmetric movements or posture (e.g. head turning or unilateral limb dystonia). Preceding symptoms/aura may be reported by the patient or a witness. Those commonly seen in temporal lobe epilepsy include an epigastric 'rising' sensation, olfactory or gustatory auras, autonomic symptoms, and experiential phenomena such as déjà vu, jamais vu and fear. The speed of recovery is typically slower for a seizure than for a syncopal episode. Postictal confusion or amnesia, and evidence of tongue biting (especially lateral), incontinence and lateralising neurological symptoms or signs are suggestive of seizures.

The EEG can establish the diagnosis of epilepsy and

distinguish between focal and primary generalised epilepsy, but a normal EEG between seizures is not uncommon in clinical practice and does not exclude a diagnosis of epilepsy. An MRI brain scan is usually mandatory. This may reveal lesions that may have triggered seizures, such as brain tumours and vascular malformations, and may also point to certain characteristic patterns that can refine the diagnosis and guide treatment.

Treatment should ideally be started and managed by

tertiary care epilepsy specialists. Overall, 60-70% of patients will respond to monotherapy at the appropriate maintenance dose. It is important to recognise drug resistant epilepsy, which is defined as 'failure of adequate trials of two tolerated and appropriately chosen and used antiseizure medications (ASMs), whether as monotherapy or in combination, to achieve sustained seizure freedom'.

GPs can improve outcomes by: sharing any new

information which may help refine the diagnosis; identifying and treating comorbidities, especially psychiatric disorders; checking ASM adherence; monitoring seizure control and ASM tolerability; early referral to, or communication with, the neurologist about treatment failure and drug resistant epilepsy; reminding patients, family/friends and carers of safety advice; signposting to educational resources.