

Management of a child after a first afebrile seizure(s)

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(Based on an adaptation of Childhood Seizure Guideline; An evidence and consensus based guideline for the management of a child after a seizure¹)

Disclaimer

Clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague. Caution is advised when using guidelines after a review date.

Scope

This guideline is for paediatric health professionals managing children > 3 months presenting to acute services with an afebrile seizure(s). These recommendations may not be appropriate for use in all circumstances. It forms part of a framework of guidelines for children with different types of seizure presenting to different services. Afebrile seizure components of this are highlighted in red (see chart)

Introduction

Approximately 10% of the UK population will have at least one seizure at some point in their lives. A seizure may be epileptic or non-epileptic. An epileptic seizure may or may not be secondary to an acute neurological or other acute generalised illness (i.e. an acute symptomatic seizure). A first seizure or seizure cluster caused by an acute illness (acute symptomatic seizure) is unlikely to recur (3-10% recurrence). Some children after a first epileptic seizure will go on to have further epileptic seizures and be diagnosed with epilepsy.¹ After a first unprovoked epileptic seizure 30-50% will recur; after a second unprovoked epileptic seizure 70-80% will recur.² There are many different types of epilepsies and it is important to structure management of the individual around their particular seizure and epilepsy type and associated problems.

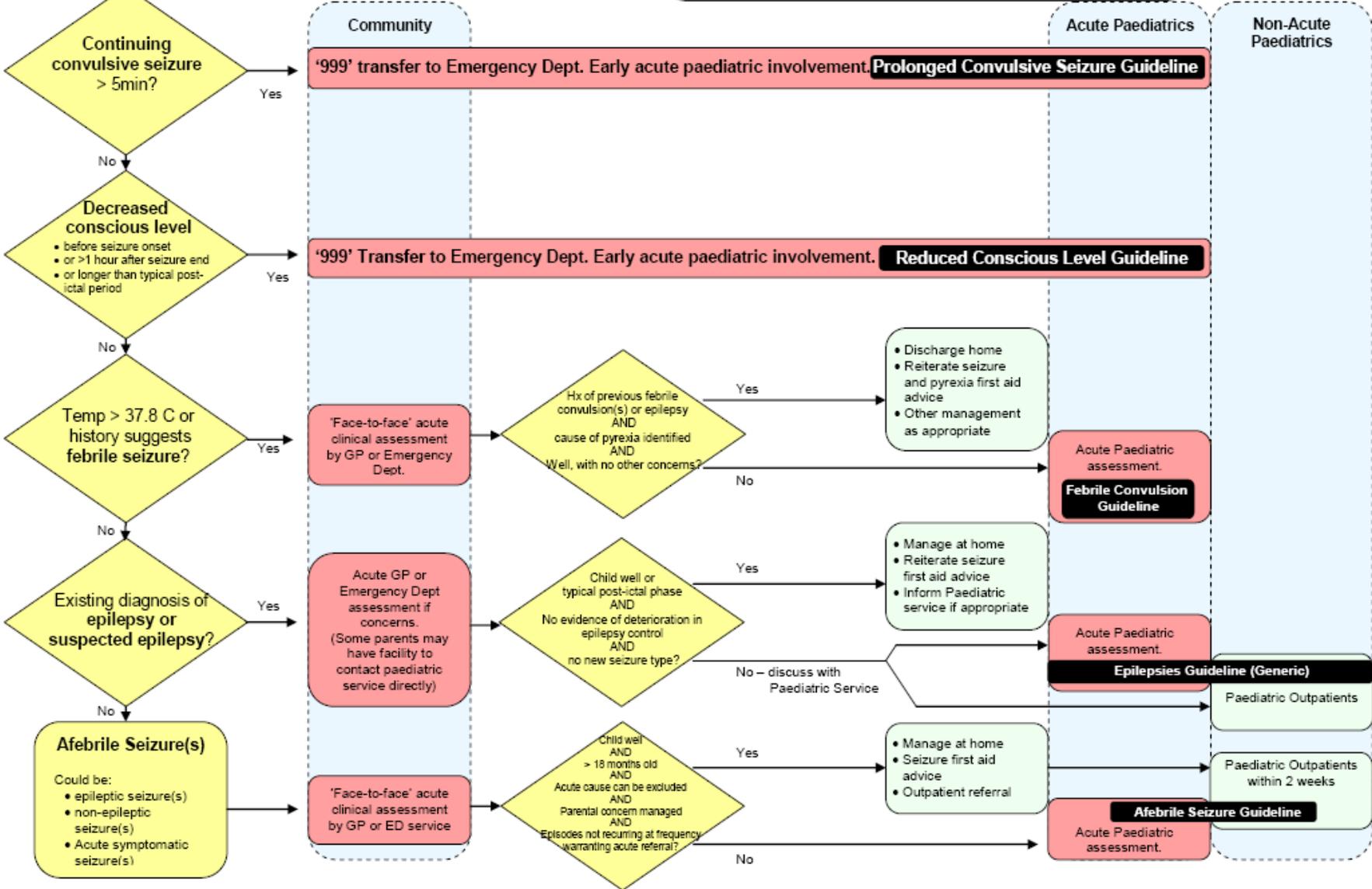
All children with a first seizure require paediatric assessment, advice and follow up. Not all children require investigation.

Definitions

Important definitions to understand in the context of this guideline are summarised in the **Glossary**.

Child (>3 months) with Seizure(s)

A seizure can be...
 ...epileptic or non-epileptic
 ... convulsive or non-convulsive
 ... febrile or afebrile
 ... isolated or recurrent.
 ... from an identifiable underlying cause or not



Community

Acute Paediatrics

Non-Acute Paediatrics

'999' transfer to Emergency Dept. Early acute paediatric involvement. **Prolonged Convulsive Seizure Guideline**

'999' Transfer to Emergency Dept. Early acute paediatric involvement. **Reduced Conscious Level Guideline**

'Face-to-face' acute clinical assessment by GP or Emergency Dept.

Hx of previous febrile convulsion(s) or epilepsy AND cause of pyrexia identified AND Well, with no other concerns?

- Discharge home
- Reiterate seizure and pyrexia first aid advice
- Other management as appropriate

Acute Paediatric assessment. **Febrile Convulsion Guideline**

Acute GP or Emergency Dept assessment if concerns. (Some parents may have facility to contact paediatric service directly)

Child well or typical post-ictal phase AND No evidence of deterioration in epilepsy control AND no new seizure type?

- Manage at home
- Reiterate seizure first aid advice
- Inform Paediatric service if appropriate

Acute Paediatric assessment. **Epilepsies Guideline (Generic)**

Paediatric Outpatients

Afebrile Seizure(s)
 Could be:
 • epileptic seizure(s)
 • non-epileptic seizure(s)
 • Acute symptomatic seizure(s)

'Face-to-face' acute clinical assessment by GP or ED service

Child well AND > 18 months old AND Acute cause can be excluded AND Parental concern managed AND Episodes not recurring at frequency warranting acute referral?

- Manage at home
- Seizure first aid advice
- Outpatient referral

Acute Paediatric assessment. **Afebrile Seizure Guideline**

Paediatric Outpatients within 2 weeks

This guideline is principally aimed at those children presenting acutely to paediatric services. Some of the information however will be applicable to those children presenting non-acutely.

It is worth considering that a seizure is a non-specific term and can be considered as a symptom or manifestation of a number of conditions or diseases.

A seizure can be...
...epileptic or non-epileptic
... convulsive or non-convulsive
... febrile or afebrile
... isolated or recurrent.
... from an identifiable underlying cause or not

Children with prolonged convulsive seizures, febrile seizures, reduced conscious level or an existing diagnosis of epilepsies, suspected epilepsies or other paroxysmal disorder should be managed by their respective guidelines.

The main differential when a child presents after a first non-prolonged, afebrile seizure(s), without significant reduced conscious level will be:

Afebrile Seizure(s)

Could be:

- epileptic seizure(s)
- non-epileptic seizure(s)
- acute symptomatic seizure(s)

There are several aims of initial assessment:

- Initial management
- Clinical evaluation
- Rapid and accurate management of any underlying acute cause
- Diagnosis and subsequent management

Initial management

A continuing convulsive seizure with loss of consciousness is a paediatric emergency. Ensure First aid/ABC etc including adequate airway and oxygenation, stable vital signs and normal blood sugar.

- Children continuing to convulse with loss of consciousness > 5 minutes should be managed according to the **prolonged seizure guideline**
- Children with evidence of pyrexia >37.8°C associated with the seizure, or who have a history suggesting a febrile seizure should be managed according to the **febrile seizure guideline**

- Children with decreased conscious level preceding the seizure or persisting >1 hour post termination of seizure should be managed according to the **decreased conscious level guideline**
- Children with an existing diagnosis of epilepsies, suspected epilepsies or other paroxysmal disorder should be managed by the **epilepsies guideline** or their individual **care plan**

Clinical evaluation

History and examination is fundamental to making an accurate diagnosis. Misdiagnosis is a major problem in children with seizures and epilepsies.

The following information should be pursued in **all** children presenting with a seizure. A first-hand witness account should be obtained in all children if possible.

Elements of history

Who is the history from?

Who witnessed the seizure?

Features of the seizure(s):

- *When it happened?*
- *Context in which the seizure happened*
- *Presence, absence and nature of any trigger*
- *Any pre-seizure symptoms reported by patient (dizziness, visual symptoms, auditory symptoms, epigastric sensations etc)*
- *Onset of seizure (focal component?, was onset seen?)*
- *Nature of actual seizure including:*
 - Motor component*
 - Vocalisations*
 - Degree of responsiveness*
 - Any laterality*
 - Eye/Head deviation*
 - Duration*
- *Post seizure details including*
 - Drowsiness or confusion*
 - Incontinence*
 - Injury*
 - Behavioural change*
 - Any other features including headache, vomiting, weakness.*

Other Features:

- *Health preceding seizure onset—febrile, intercurrent illness? sleep deprived? encephalopathy? fluid balance problems? etc.*
- *Family history of arrhythmias, sudden death, sensorineural deafness, faints, epilepsies etc.*
- *Early development and current developmental milestones*
- *Learning, behaviour, concentration problems, schooling problems etc.*

All children require a thorough examination including:

- Neurological assessment and conscious level
- BP and cardiovascular examination
- Head circumference
- Chvostek's sign (ipsilateral facial contraction on percussion of the facial nerve which suggests hypocalcemia)
- Signs of dysmorphism or neurocutaneous syndromes

Rapid and accurate management of any underlying acute cause

The child should be assessed to determine whether there could be an acute underlying cause (i.e. an acute symptomatic seizure). Seizures secondary to hypoglycaemia, hyponatraemia, encephalitis etc. are examples of this.

NB. Beware the child presenting with tonic or tonic-vibratory seizures. These may be non-epileptic episodes that could indicate raised intracranial pressure i.e. decerebrate / decorticate posturing. (Epileptic tonic seizures are rare as a presenting seizure type in neurodevelopmentally intact children).

Consider need for admission³

For guidance only. Social circumstances should also be considered. If in doubt discuss with senior colleague.

Parameter	Criteria / Signs
Age	Less than 18 months & presenting acutely
Neurology	Glasgow coma score (or equivalent) <15 (>1 hour post-seizure) (See <i>Decreased Conscious Level Guideline</i>) New neurological signs
Raised intracranial pressure	Papilloedema, tense fontanelle etc
Generally unwell	Irritable, uninterested, vomiting etc
Meningism	Kernig's sign positive, photophobia, neck stiffness etc
Nature of seizure	Seizures presenting acutely with duration >10 minutes, focal, recurrent or required emergency treatment
Signs of aspiration	Respiratory distress, need for oxygen, chest signs.
High parent or carer anxiety	For example, parents / carers do not feel happy to take the child home following a full discussion
Frequent seizures	Seizures are in keeping with an epilepsy requiring urgent inpatient management e.g. infantile spasms

Investigations

No investigations are routinely indicated in a child over 18 months of age with an afebrile seizure who does not fulfil the criteria for admission.

Glucose

A finger prick blood glucose should be performed if a child is still seizing or not fully alert.

ECG

All children with convulsive seizures should have a 12 lead ECG recorded with calculation and documentation of QTc (Corrected QT interval) to look for evidence of cardiac disease⁴ (see Appendix 2). Prolonged QTc may indicate long QT syndrome. Children with arrhythmias or other causes of syncope can present with convulsive syncopal seizures that mimic epileptic seizures.

U&E, Ca, Mg, FBC, Urine toxicology

These tests are undertaken if child <18 months or clinical features are suggestive.

EEG⁵

An EEG should be performed in children with **recurrent** (more than 1) suspected **epileptic** seizures. Occasionally EEG may be appropriate after a first epileptic seizure or where there is uncertainty about the nature of additional ongoing episodes. Individuals requiring an EEG should have the test performed soon (<4 weeks) after it has been requested.⁵ Some may require an acute inpatient EEG.

EEG may reveal useful information to help define an epilepsy syndrome. Also unequivocal epileptiform activity shown on EEG can be used to assess the risk of seizure recurrence.

NB. A normal EEG does not exclude an epilepsy. A significant proportion of children **without** epilepsy have an abnormal EEG (5-32% depending on definition of abnormal).⁴

CT/MRI⁵

If a neuroimaging study is indicated, MRI is the preferred modality. CT should be used if MRI is not available or is contraindicated. There are 2 settings where neuroimaging should be considered:

1. In an acute situation, neuroimaging is used to determine whether a seizure has been caused, or is associated with, an acute neurological lesion or illness e.g. traumatic brain injury, encephalitis, intracranial abscess, raised intracranial pressure, unexplained encephalopathy, brain tumour.⁶ CT is usually performed as this is often more available acutely.
2. MRI should be considered in the following children soon (within 4 weeks)⁵
 - Children who develop recurrent epileptic seizures before the age of 2 years

- Children with recurrent epileptic seizures who have any suggestion of a focal onset on history, examination or EEG (unless clear evidence of Benign Rolandic Epilepsy (BRE))
- Children in whom epileptic seizures continue in spite of first-line medication
- Suspected neurocutaneous syndromes

Neuroimaging is **not** routinely indicated after a first seizure, in children with idiopathic generalised epilepsies (e.g. Childhood and Juvenile Absence Epilepsies, Juvenile Myoclonic Epilepsy etc) or BRE. Some children may have indications for neuroimaging for reasons other than epilepsy e.g. learning difficulties, cerebral palsy, neuroregression.

Lumbar puncture

An LP is indicated if there is a concern of possible meningitis or encephalitis. If increased intracranial pressure is suspected, the LP should be preceded by an imaging study of the head. **A normal CT scan does not rule out acutely raised ICP.** Further guidance regarding this is available within the reduced conscious level guideline.

Diagnosis and subsequent management

The following table illustrates management options depending on the seizure. It may be difficult for a variety of reasons to be clear which cause is the most likely for a given child. If there is uncertainty it is better to acknowledge this rather than make a premature diagnosis of an epilepsy.

	Acute symptomatic seizure(s)	Non-epileptic seizure(s)	Single epileptic seizure	Recurrent epileptic seizures i.e. epilepsy
Definition	Epileptic seizure(s) secondary to a concurrent underlying acute illness	A seizure not caused by epileptic neuronal discharge that may or may not be secondary to an underlying acute illness	An epileptic seizure not secondary to an underlying acute illness	A number of epileptic seizures or seizure types (generally continuing to recur in time period >24 hours)
Typical presentation and patient journey	Will predominantly present acutely with criteria for admission and require inpatient paediatric management	May present acutely or non-acutely. Some will require paediatric assessment and management	May present acutely or non-acutely. All require acute or outpatient paediatric assessment	May present acutely or non-acutely depending on type of seizure(s) & epilepsy. All require acute or outpatient paediatric assessment and ongoing management.
Differential Diagnosis	<ul style="list-style-type: none"> intracranial infection (bacterial/viral, diffuse/localised) ingestion (deliberate, accidental) trauma (head injury, non accidental injury) tumour intracranial haemorrhage hypertension metabolic (low glucose, calcium, magnesium, high and low sodium, amino and organic acidurias etc) others 	e.g. <ul style="list-style-type: none"> cardiac arrhythmia syncope vasavagal syncope reflex anoxic seizures blue breath-holding attacks tics Sandifers 'behavioural' raised intracranial pressure Many to consider: See appendix 1 for diff diagnosis flowchart	Consider type of seizure(s): e.g. <ul style="list-style-type: none"> uncertain generalised or focal convulsive or non-convulsive tonic tonic-clonic dialeptic (e.g. typical absence) myclonic spasm <ul style="list-style-type: none"> focal motor focal sensory focal with automatisms 	Consider type(s) of seizure and epilepsy syndrome There are different types of epilepsies and each should be classified over time according to ILAE multiaxial classification: <ol style="list-style-type: none"> Seizure semiology Seizure type(s) Epilepsy Syndrome Aetiology Assoc. impairment
General management for all	<ul style="list-style-type: none"> Appropriate history and examination All children with first afebrile convulsive seizure (except acute symptomatic where cause clearly defined) should have 12 lead ECG² (with calculation of QTc: see appendix 2) FBC, U&E, Ca, Mg not routinely required unless suggested by history or examination or age < 18 months Consider outpatient paediatric appointment following an acute admission 			
Specific inpatient management (see table 1 for indications for admission)	Consider: <ul style="list-style-type: none"> Bloods(Glucose, FBC, U&E, Ca, Mg) CT head LP Meningitis or Encephalitis management Management according to underlying cause	According to underlying cause		<ul style="list-style-type: none"> Consultant review. Consider inpatient EEG in some. Consider inpatient neuroimaging in some Consider acute treatment in some. Epilepsy nurse review
Specific ongoing management at discharge / outpatients	<ul style="list-style-type: none"> Depends on specific diagnosis Information leaflet etc. Consider follow-up 	<ul style="list-style-type: none"> Depends on specific diagnosis Information leaflet etc. Consider follow-up 	<ul style="list-style-type: none"> Seizure first aid advice Ensure <u>full recovery</u> before discharge EEG <u>not</u> indicated routinely Consider buccal midazolam + training if prolonged convulsive seizure >10 minutes 	<ul style="list-style-type: none"> Seizure first aid advice Standard EEG indicated (aim for outpatient EEG within max 4 weeks – some children consider inpatient EEG) Give info leaflet e.g. Epilepsy action Epilepsy nurse - Care plan including individual emergency plan Consider buccal midazolam + training if prolonged convulsive >10 minutes Request home video Outpatient MRI if not idiopathic epilepsy¹ Seizure diary See further info in epilepsies guideline

Glossary

Seizure - A seizure can be epileptic or non-epileptic. A paroxysmal abnormality of motor, sensory, autonomic or cognitive function.

Epileptic seizure - Paroxysmal abnormality of motor, sensory, autonomic, cognitive function due to transient dysfunction of the cerebral cortex characterised by excessive and hypersynchronous neuronal activity.

Non-epileptic seizure - Paroxysmal abnormality of motor, sensory, autonomic or cognitive function **not** due to an epileptic seizure.

Febrile seizure - A seizure occurring in the presence of fever ($> 37.8^{\circ}\text{C}$) or where history or clinical findings is suggestive of febrile seizures.⁷

Epilepsy - A group of chronic neurological conditions characterised by recurrent epileptic seizures.¹⁰

ED – Emergency Department

EEG - Standard Electroencephalogram

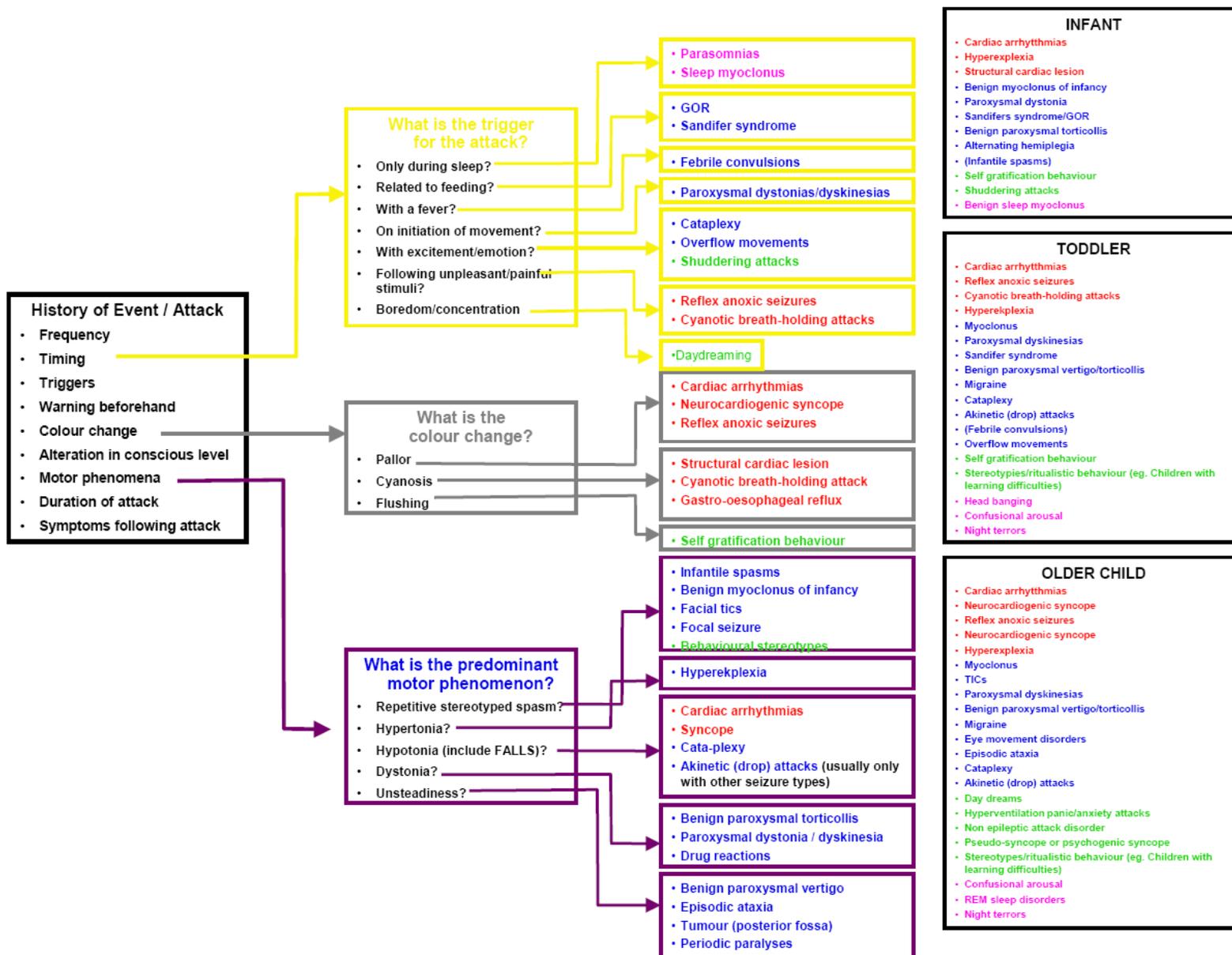
QTc - Corrected QT interval

BRE -Benign Rolandic Epilepsy

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Appendix 1. Differential Diagnosis of Epilepsy in Children (taken from NICE⁵)



Appendix 2 - Calculation of Corrected QT interval (QTc)

$$QTc \text{ (Corrected QT)} = QT / \sqrt{RR}$$

QTc Normal range = < 0.44 (SIGN Guidelines)

Prolonged QTc may indicate long QT syndrome. Children with arrhythmias can present with seizures that mimic epileptic seizures.

