Epilepsia: Actualización en Epilepsia?

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Congreso Argentino de Pediatría Ambulatoria, Salta 8 de Noviembre de 2018

Epilepsia: temas a desarrollar

- Definición epilepsia ILAE 2014
- Orientación clínica
- Clasificación epilepsia ILAE 2017
- Diagnóstico

Relevancia a la presentación electro-clínica

Importancia de la Genética y nuevos estudios (identificando características electro-clínicas y su confirmación genética)

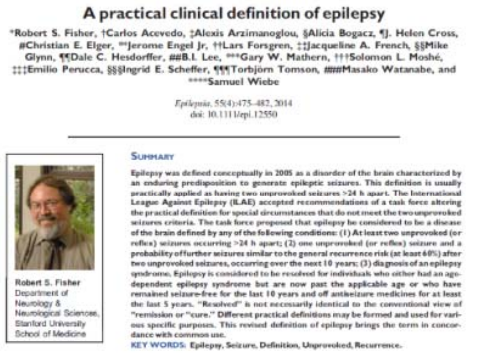
- Tratamiento
- DAE
- Tratamientos alternativos

Epilepsia: definición

- **Crisis epilépticas:** aparición transitoria de síntomas y signos provocados por una actividad neuronal anómala y excesiva o simultánea en el cerebro.

- **Definición de Epilepsia:** es un trastorno cerebral que se caracteriza por una predisposición crónica a crisis epilépticas y por las consecuencias neurobiológica, cognitivas, psicológicas y sociales de esta enfermedad.

Epilepsia: definición



A practical clinical definition of epilepsy

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SUMMARY

Epilepsy was defined conceptually in 2005 as a disorder of the brain characterized by an enduring predisposition to generate epileptic seizures. This definition is usually practically applied as having two unprovoked seizures >24 h apart. The International League Against Epilepsy (ILAE) accepted recommendations of a task force altering the practical definition for special circumstances that do not meet the two unprovoked seizures criteria. The task force proposed that epilepsy be considered to be a disease of the brain defined by any of the following conditions: (1) At least two unprovoked (or reflex) seizures occurring >24 h apart; (2) one unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%) after two unprovoked seizures, occurring over the next 10 years; (3) diagnosis of an epilepsy syndrome. Epilepsy is considered to be resolved for individuals who either had an age-dependent epilepsy syndrome but are now past the applicable age or who have remained seizure-free for the last 10 years and off antiseizure medicines for at least the last 5 years. "Resolved" is not necessarily identical to the conventional view of "remission or "cure." Different practical definitions may be formed and used for various specific purposes. This revised definition of epilepsy brings the term in concordance with common use.

KEY WORDS: Epilepsy, Seizure, Definition, Unprovoked, Recurrence.

- 2 crisis no provocadas separadas por más de 24 h
- Una crisis en el contexto de un síndrome epiléptico
- Una crisis no provocada (o refleja) y probabilidad de que aparezcan más crisis durante los 10 años siguientes similar al riesgo de recurrencia general (al menos el 60% después de 2 crisis no provocadas).

Fisher R, Epilepsia 2014

Epilepsia: enfoque clínico

- Convulsión sintomática: Debido a un insulto agudo del SNC de causa intracerebral o extracerebral

- Epilepsia sintomática: Debido a lesión cerebral

- Epilepsia idiopática: Reúne criterios clínico- EEG definidos de probable origen genético

- Epilepsia criptogénica: de origen oculto (después probablemente sintomática)

Epilepsia: enfoque clínico

CONVULSION AGUDA SINTOMATICA

TCE
Hipoglucemia
Meningitis aguda
Etc.

EPILEPSIA

IDIOPATICA

- Genética
- Desarrollo normal
- Examen neurológico N
- TAC-RMN N
- EEG característico

SINTOMÁTICA

- Secundaria (insulto SNC)
- Antecedentes Personales

y/o Examen neurológico y/o TAC-RMN anormal

PROBABLEMENTE SINTOMATICA

- Origen oculto. Secundaria a una lesión no demostrable
- (Antec-Imágenes)
- Se sospecha una lesión

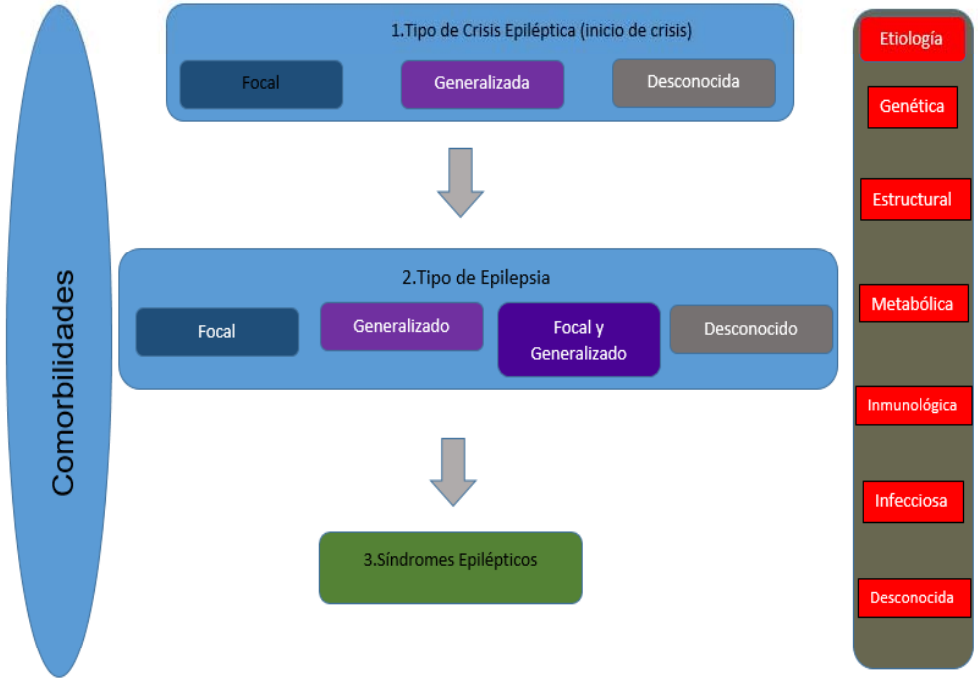
por evolución o por forma de presentación

Epilepsia: Clasificación de ILAE 2016, 2017


Epilepsia Open
SPECIAL REPORT

Classification of the epilepsies: New concepts for discussion and debate—Special report of the ILAE Classification Task Force of the Commission for Classification and Terminology

Figura 2. Esquema para la Clasificación de las epilepsias (2017)



Scheffer IE et al. ILAE classification of the epilepsies: Position of the ILAE Commission for Classification and Terminology. Epilepsia 2017; 1-10

Clasificación Epilepsia: Aplicación y utilidad HPMI (Salta)

- **Objetivo**

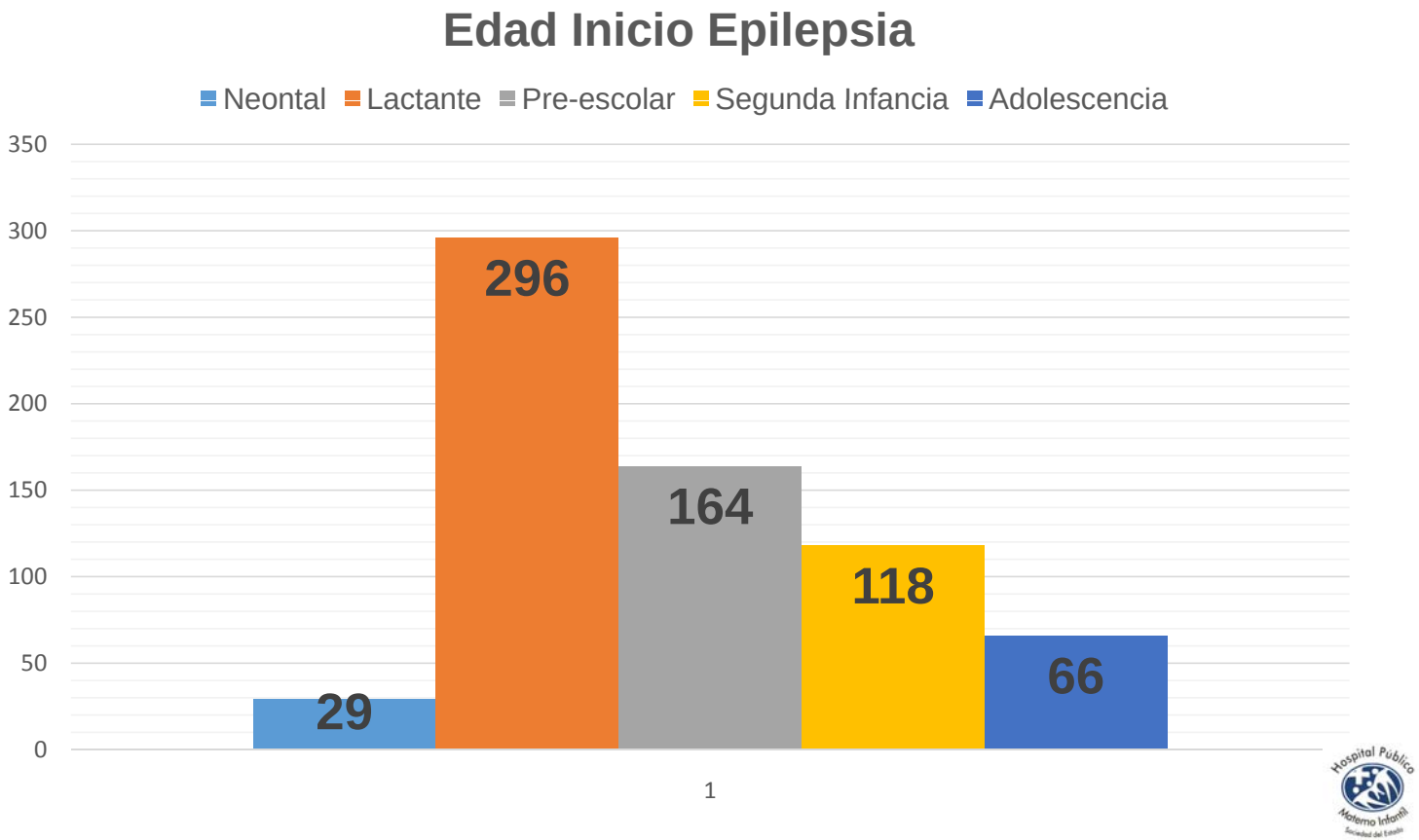
Analizar la aplicación y utilidad clínica de la Nueva Clasificación de Epilepsia de la ILAE, usando los nuevos conceptos y el nuevo marco de diagnóstico de esta propuesta en el Hospital Público Materno Infantil de Salta.

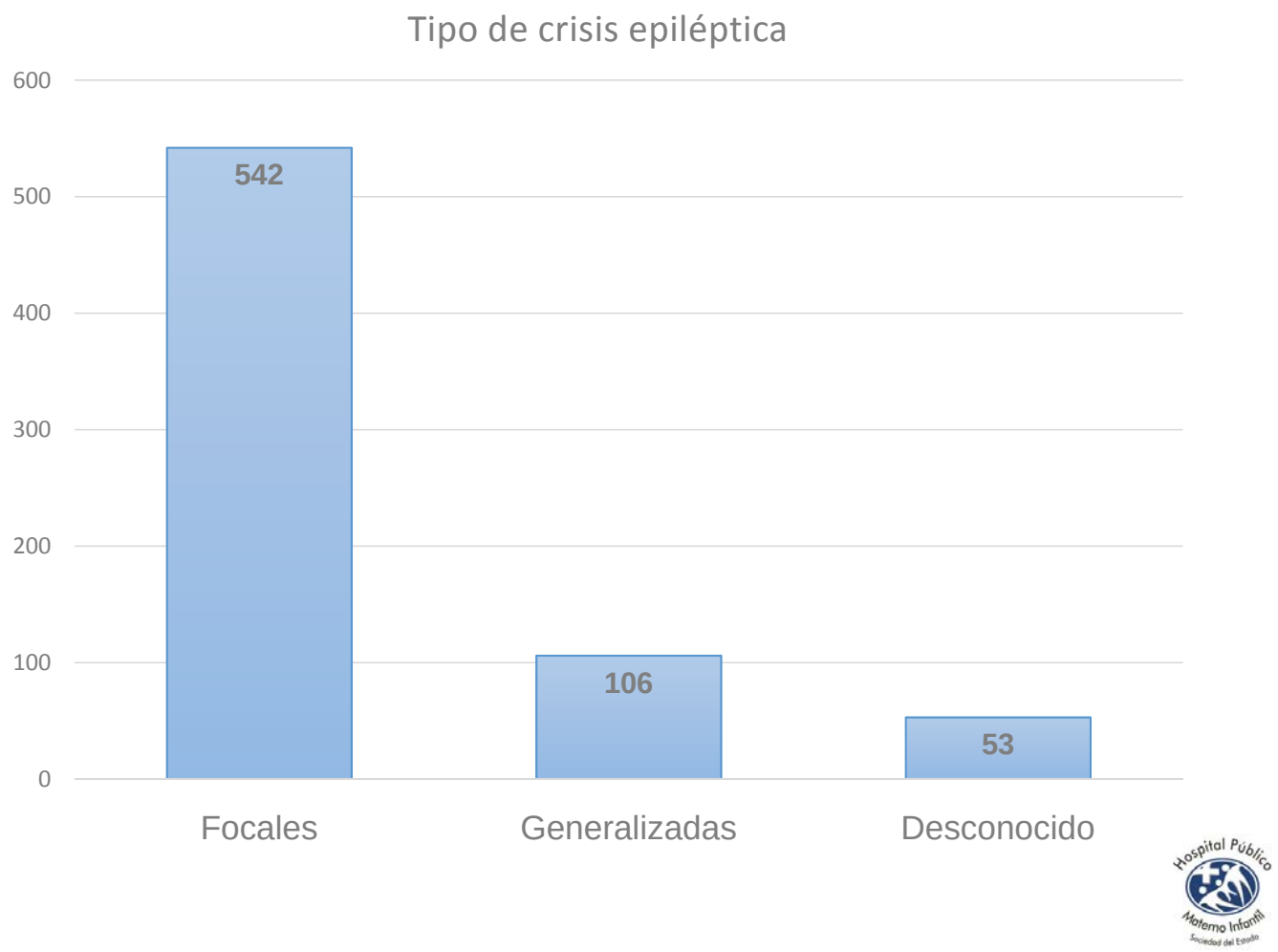
Material y Métodos

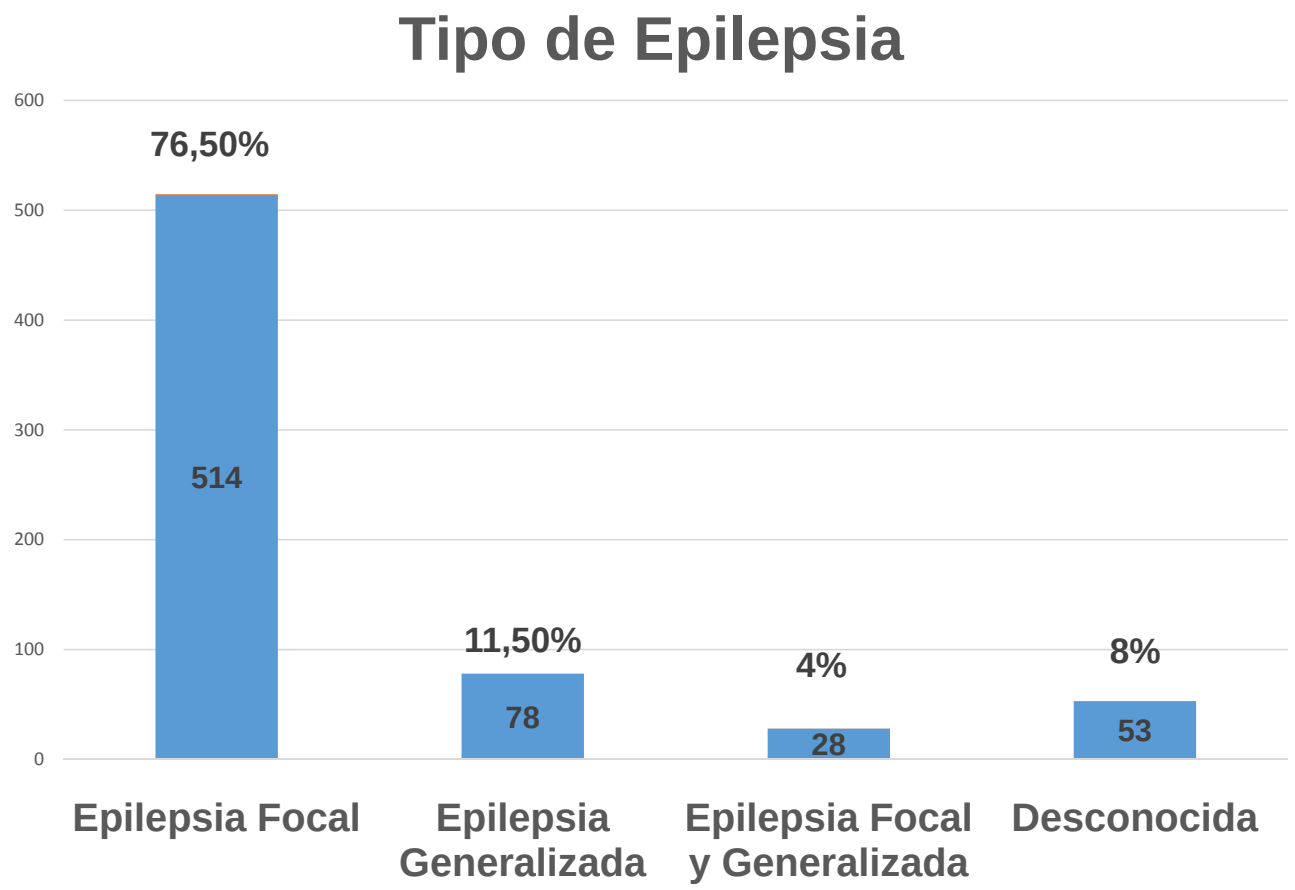
- Estudio Prospectivo
- Se evaluaron 673 pacientes entre 1 agosto 2016 a 31 julio 2017
- Se analizaron todos los pacientes que concurrieron consecutivamente al control, en consultorio externo, emergencia y hospitalización HPMI.
- Criterios diagnósticos de epilepsia de acuerdo a definición de Fischer
- Clasificar de acuerdo a Clasificación multinivel de Scheffer, 2016, 2017

Resultados

- 569/673 (85,5%) se pudo identificar el Síndrome epiléptico o Etiología de la Epilepsia
- Epilepsia con Etiología: 389 casos (58%)
- Etiología Desconocida: 284 casos (42%)
- En 377 (56%) se reconoció el Síndrome Epiléptico, de los cuales 180 (47.5%) tenían etiología desconocida

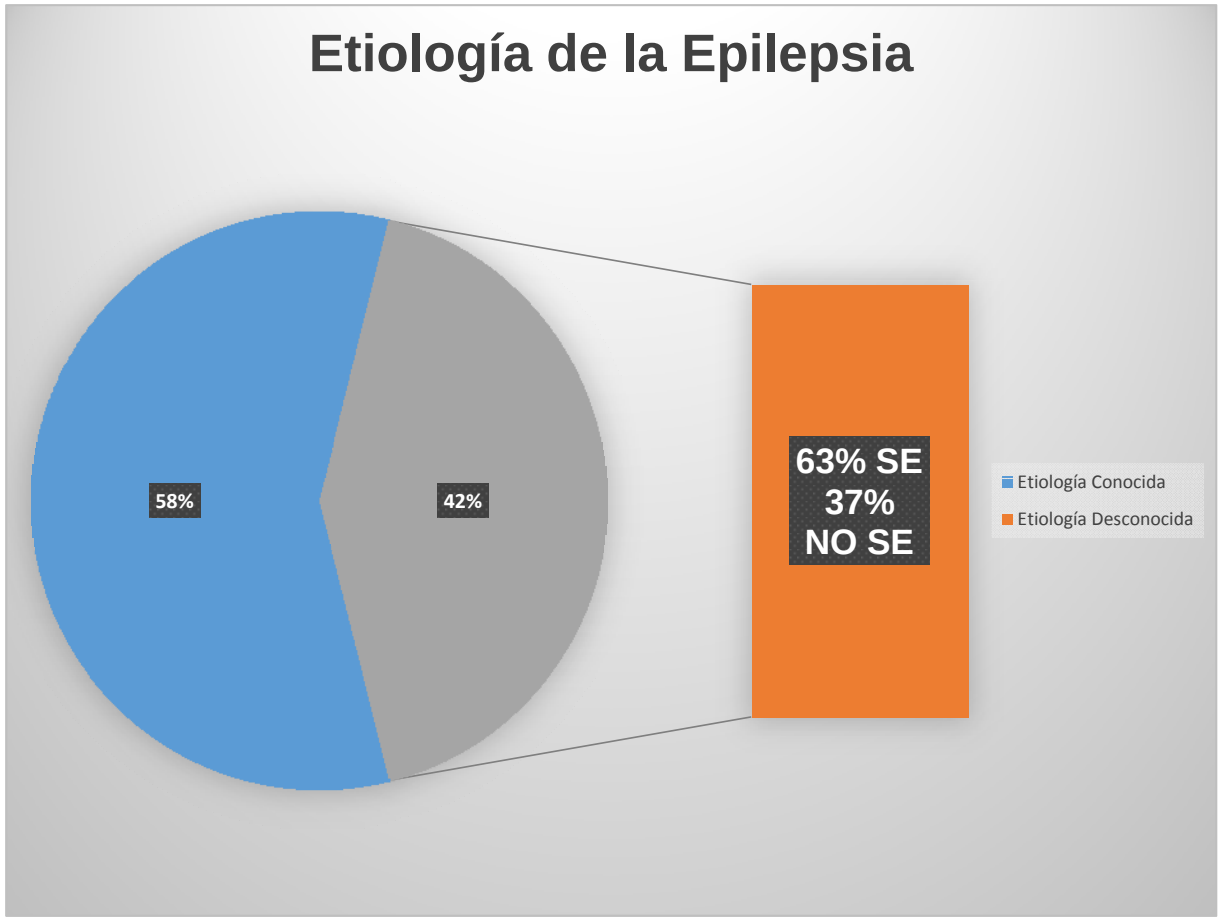

Edad Inicio Epilepsia
Neontal
Lactante
Pre-escolar
Segunda Infancia
Adolescencia
350
300
250
200
150
100
50
0
29
296
164
118
66
1


Tipo de crisis epiléptica
600
500
400
300
200
100
0
542
106
53
Focales
Generalizadas
Desconocido



- **104/673 (15.5%) casos solo se llego a este nivel**

Etiología de la Epilepsia



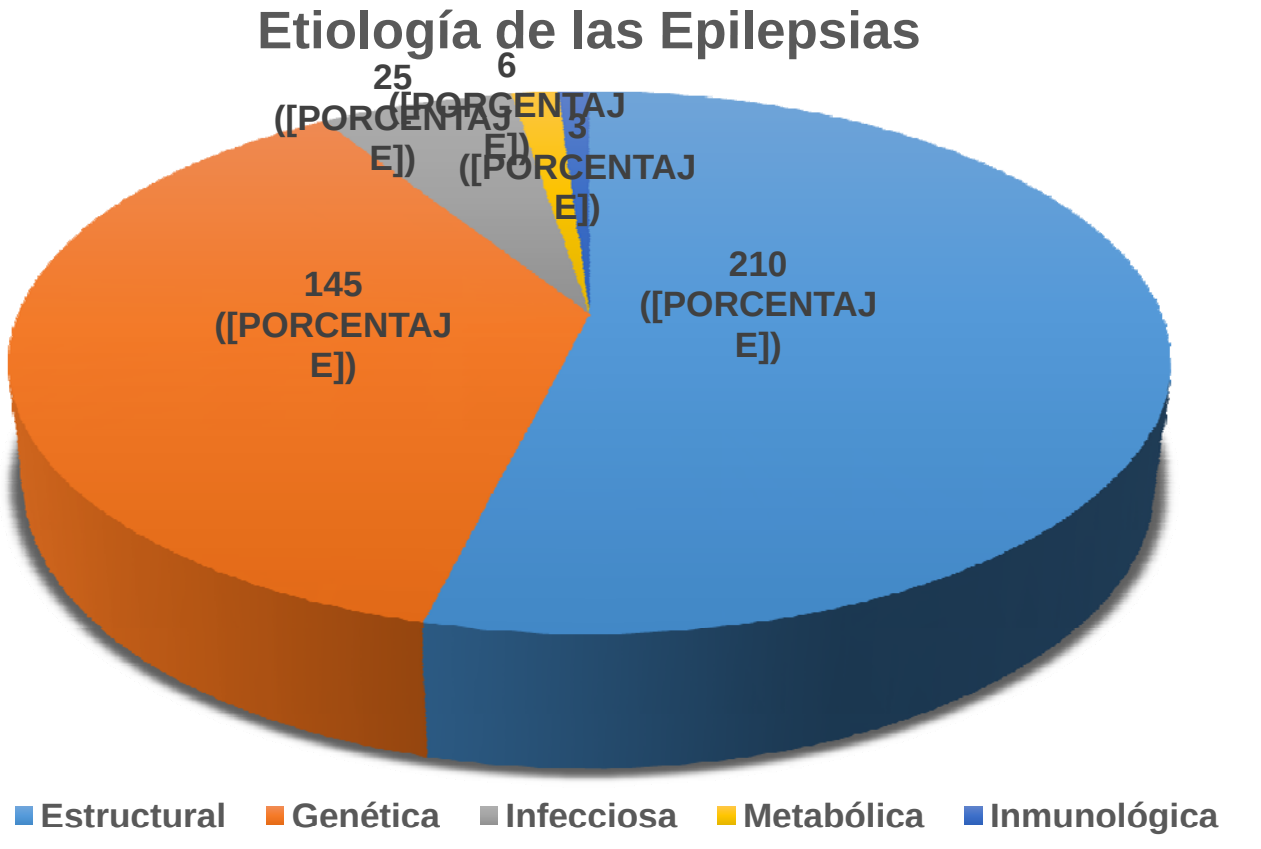
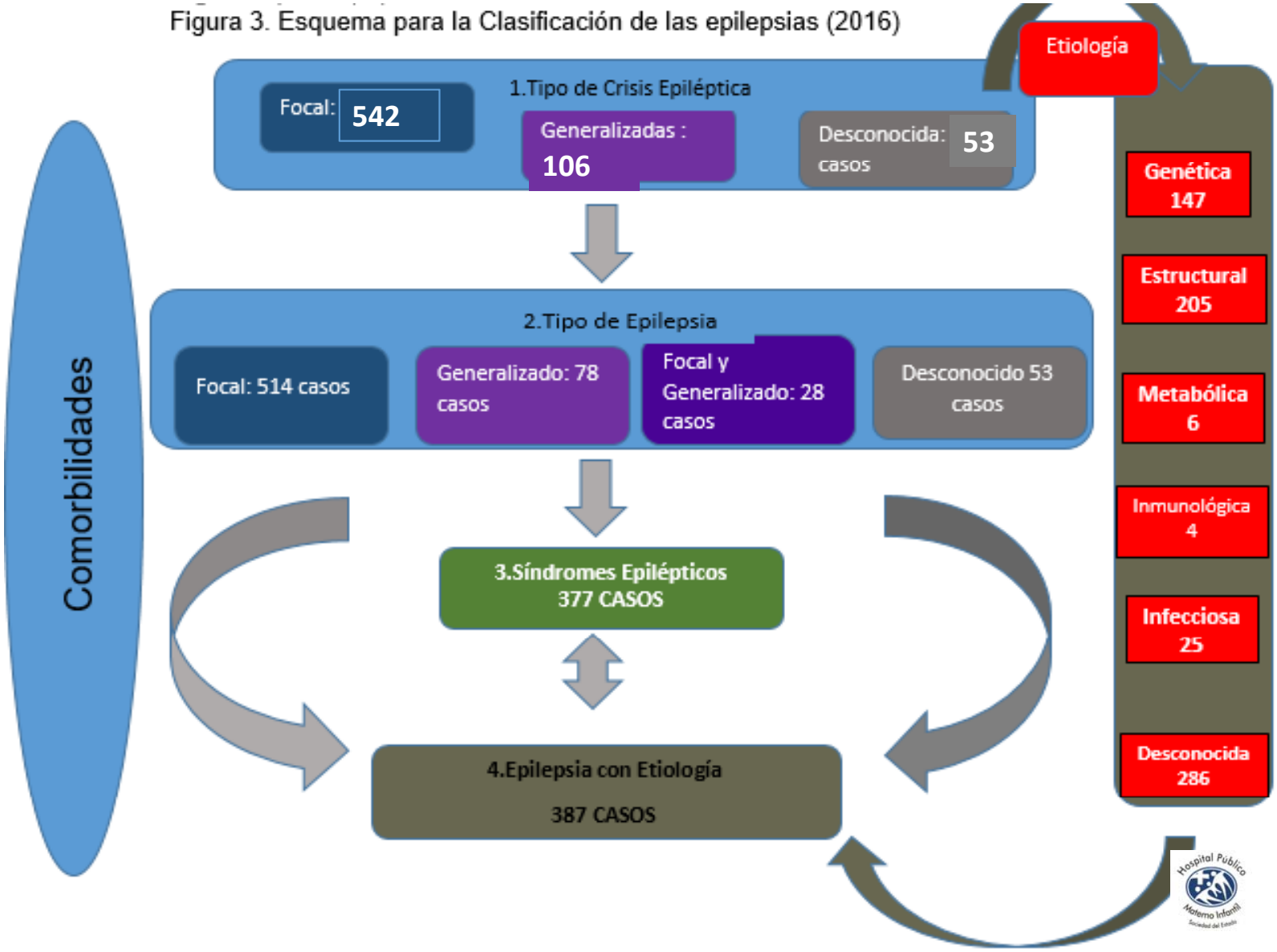

Etiología de las Epilepsias
25 ([PORCENTAJE])
6 ([PORCENTAJE])
3 ([PORCENTAJE])
145 ([PORCENTAJE])
210 ([PORCENTAJE])
Estructural
Genética
Infecciosa
Metabólica
Inmunológica

Figura 3. Esquema para la Clasificación de las epilepsias (2016)



Conclusiones y comentarios

- La Nueva propuesta de Clasificación pudo aplicarse y es útil en la población que concurrió a Nuestro Hospital.
- El tipo de crisis focal y el tipo de epilepsia focal fueron el grupo más frecuente en nuestra serie
- En la mayoría pudo reconocerse la etiología de la epilepsia y/o un SE con características electro-clínicas y evolutivas distintivas

Epilepsia: Diagnóstico

- EEG vigilia, sueño, HV, Fotoestimulación
- Video EEG
- TAC de cerebro
- RMN de cerebro
- SPECT Ictal
- PET
- Genética

De la Valoración electro-clínica a la Genética

Original article

Epileptic Disord 2003; 5: 45-9

Benign familial and non-familial infantile seizures: a study of 64 patients

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ABSTRACT – *Introduction:* The recently proposed diagnostic scheme for people with epileptic seizures and with epilepsy (*Epilepsia 2001*) includes two idiopathic focal epileptic syndromes with onset during the first year of life, the benign familial and non-familial infantile seizures.
Objective: To analyze the electroclinical features and evolution in patients with benign familial and non-familial infantile seizures.
Patients and methods: Sixty-four patients (36 males and 28 females) were evaluated at the Neurology Department of the J. P. Garrahan Children's Hospital between February 1990 and December 2001. We analyzed gender, age at onset, duration, manifestations, circadian distribution and frequency of seizures, family history of epilepsy and paroxysmal dyskinesias. EEG and neuroradiological studies were performed. The semeiology of the seizures was analyzed only according to the description in the clinical history. Ictal EEGs could not be recorded.
Results: Twenty-five patients, 14 girls and 11 boys, had a family history of similar seizures with an age at seizure onset of 3 to 22 months (median of 5.5 months). Nine patients (36%) had apparently generalized convulsions only; five patients (20%) partial seizures only and ten patients (50%) had both partial and generalized seizures. Convulsions were brief, during wakefulness in all, and occurred in clusters in 12 patients (48%). Interictal EEG was normal in 24 patients (96%).
Similar seizures and age at onset were found in 14 fathers, ten mothers and one uncle of these patients. Twenty-two patients (88%) had their last seizure before the age of 30 months. Two siblings of the same family later had brief episodes of paroxysmal kinesigenic dyskinesia, which in one of them were associated with infantile seizures. Later, two fathers developed paroxysmal kinesigenic dystonia. One of them also had had infantile seizures. A second group of 39 patients (25 boys and 14 girls) showed similar electroclinical features and evolution but there was no history of infantile seizures in first-degree relatives family history of epilepsy was found in 12.8% of second-degree relatives, but the type of epilepsy could not be defined.
Conclusion: This study comfirms the existence of a familial benign epileptic syndrome in infancy, of probable dominant autosomical transmission.
A large group also had similar electroclinical features but without a family history. We discuss the possible relationships between the two groups and suggest that further genetic studies may solve the problem.

KEY WORDS: autosomal dominant, familial infantile seizures or convulsions, idiopathic epilepsy, non-familial infantile seizures or convulsions, paroxysmal choreoathetosis or dyskinesias.

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journal homepage: www.elsevier.com/locate/epilepsyres

Benign infantile seizures: A prospective study

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Available online 30 November 2009

KEYWORDS
Benign infantile seizures;
Benign focal epilepsy;
Familial infantile seizures;
Non-familial infantile seizures;
Infantile convulsions and evolution

Summary
Introduction: One idiopathic focal epileptic syndrome with onset during infancy is recognized, the benign infantile seizures (BIS).
Objective: To analyze the electroclinical features and evolution in patients with BIS and assess the difference between familial and non-familial infantile cases.
Patients and methods: We performed a prospective follow-up study in 41 patients seen at our department between September 2002 and March 2004, with BIS from 2 to 12 months of age. Among the 41 cases 6 were excluded.
Results: Thirty five had BIS after the follow-up. The follow-up was 60–77 months (median 69 months). They were divided in Group 1: 14 patients had a family history of similar seizures in infancy and Group 2: 21 without familial history of infantile epilepsy. Both groups have similar electroclinical features and family history of seizures is the only clue to the differential diagnosis. Seizures were brief, and occurred in cluster in 30 patients (85%). Interictal EEGs were normal in 34 cases (97%) and neuroimaging in all children. No one had seizures after finishing the antiepileptic treatment. Neurological examination and developmental milestones remained normal after the follow-up.
Conclusions: This study confirms the existence of BIS. Non-familial cases might represent novo mutations or sporadic cases of BIS. The recognition of BIS is possible at beginning of the epilepsy. To confirm the syndrome the follow-up is necessary.

Hospital Público Materno Infantil
Sociedad del Estado

Table 1 Results of electroclinical features compared with Caraballo et al (2007) series.

	Caraballo et al 2007		Our study	
Epilepsy syndromes	**BFIS**	**BNFIS**	**Group 1 BFIS**	**Group 2 BNFIS**
Number of cases	40	65	14	21
Age of onset (months)				
Median	6.5	9	6.5	6
Range	3-22	2-23	2-12	2-12
Types of seizures				
Focal	20 (50%)	31 (47%)	4 (29%)	3 (15%)
Apparently generalized	10 (25%)	16 (25%)	8 (57%)	11 (52%)
Secondarily generalized	10 (25%)	18 (28%)	2 (14%)	7 (33%)
In "Clusters"	21 (52%)	30 (46%)	12/14(85%)	18/21(85%)
Begin with cluster	-	-	7/14	10/21
Sporadic seizures followed by cluster	-	-	5/14	8/21
Sporadic seizures without cluster	-	-	2/14	3/21
Duration			1-3 days	1-4 days
Number of seizures			2-7	2-6
Interictal EEG				
Normal	24	37	13	21
Abnormal	1	2	1	0
Family history of BIS				
Mother or Father	39	0	12	0
Uncle	1	0	2	0
Sister			2	
Family History of others type of epilepsy	3	9	2	2
Paroxismal Choreoathetosis	8 (3 patients and 5 relatives)	0	2 fathers	0

BFIS: Benign familial infantile seizures
BNFIS: Benign non familial infantile seizures

Conclusión

- **CFBL y CBL (no familiares) presentan similares características electroclínicas**

- **Los casos no familiares podrían corresponder a mutaciones de novo o esporádicos casos de CBL**

- **Gen asociado a CBL**

Gen PRRT2 (CFBL) **(Heron y cols., 2012, Cao y cols. 2012, Ono y cols 2012)**

Casos esporádicos Gen PRRT2 + **(Spechio y cols. 2013)**

Explosión de la Genética en Epilepsia

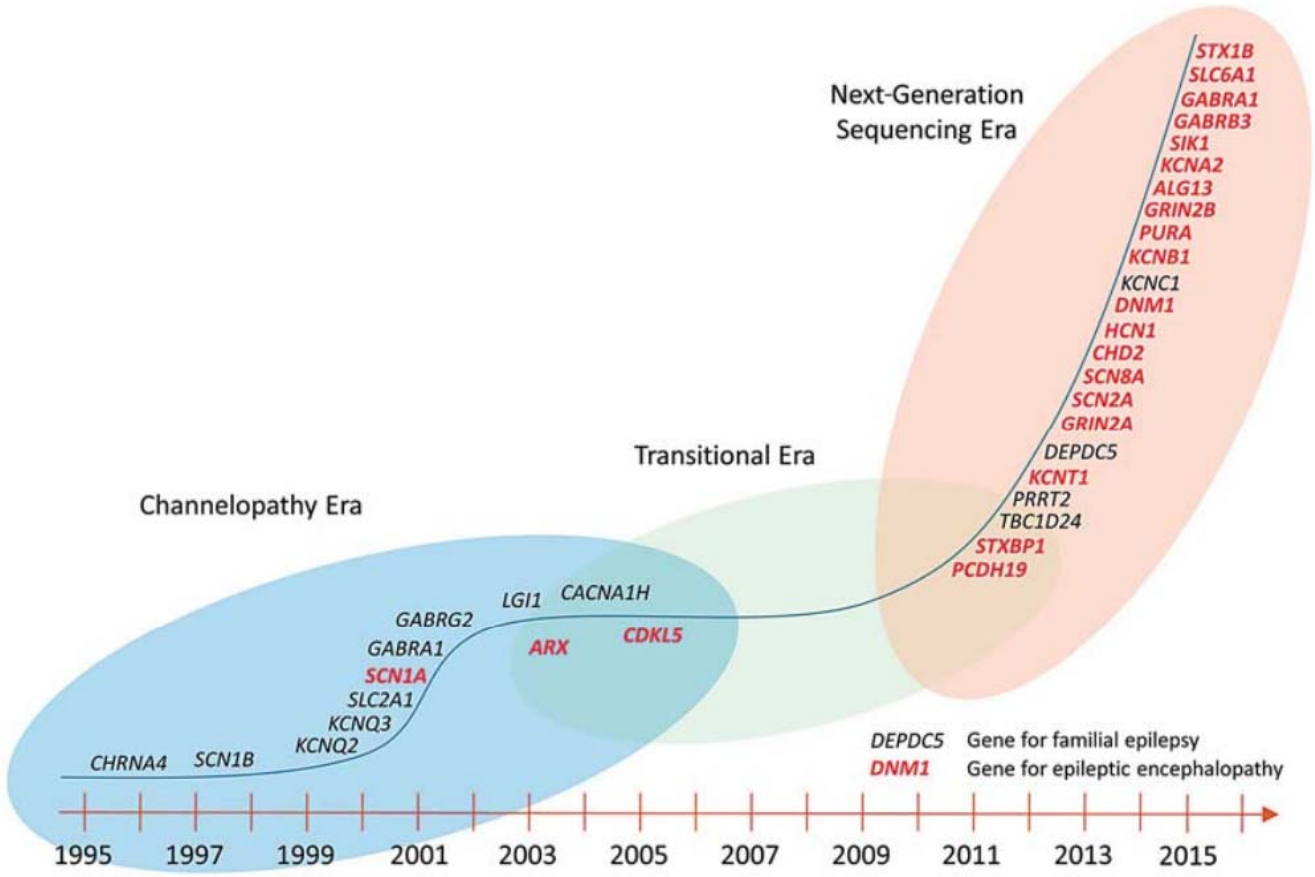

Fig. 2. Timeline of gene discovery in human epilepsies.

Epilepsias Genéticas: Etiología y Tratamiento

Validación de análisis

- Mayores avances en curso

Validación Clínica

- Clínica genética/neurología pediátrica
- Laboratorios clínicos y de investigación
- Inicio de la Epilepsia genética

Utilidad Clínica

SCN1A→avoid phenytoin and lamotrigine (generally)
SCN2A→high-dose phenytoin helpful
SCN8A→high-dose phenytoin helpful
SLC2A1→ketogenic diet
PRRT2→carbamazepine
PLCB1→inositol
ALDH7A1→pyridoxine
PNPO→pyridoxal-5-phosphate
KCNQ2→consider ezogabine for loss-of-function variants
KCNT1→consider quinidine for gain-of-function variants (trials needed)
GRIN2A→consider memantine, dextromethorphan for gain-of-function variants (trials needed)
TSC→consider everolimus
focal cortical dysplasia and other malformations of cortical development→consider everolimus or other mTOR inhibitors (trials needed)

Utilidad Personal

- Finalización de odisea diagnóstica
- (medica o padres)
- Consejo genético
- Esperanza de precisión medica y estudios de investigación

- Panduri 2017, Epilepsy Currents, 17:16-22

2016 Update

A2M	BHLHE22	CHD4	DIP2C	FETUB	HDAC4	LANCL2	MYO5A	PACS2	PTPRO	RXFP1	STK36	TTN
AAK1	BMP2	CHIA	DISP1	FLG	HECW2	LCE1A	MYO7B	PAK6	PTPRT	RYR2	**STX1B**	TTYH1
ABCA2	BMS1	CLDN19	DNAH7	FLNA	HFE	LDLRAD1	MYOM3	PALLD	PURA	RYR3	**STXBP1**	TUBB2A
ABCB9	C16orf62	CLIC5	DNAH9	FLNC	HIPK3	LEKR1	N6AMT1	PAQR8	PWWP2A	SAFB2	SVOPL	UBQLN4
ACOT4	C17orf53	CNTN5	DNAJC6	FLRT1	HIST1H2BD	LEMD2	NBAS	PASK	QRSL1	SCAF4	SYNE2	UHRF1BP1I
ADAM21	C18orf25	COL4A4	**DNM1**	FOCAD	HIST2H2BE	LETM1	NBEA	PCDHB13	RAB5C	**SCN1A**	SYTL5	UNC5CL
ADAMTSL4	C1orf123	COL7A1	DSG2	FRAT2	HLTF	LIN7A	NCBP1	PDCL2	RAD54L2	**SCN2A**	TAAR2	USP7
AGPAT3	C1orf56	COQ3	DTYMK	FRMD4A	HNRNPH1	LRP1	NCOR2	PDIK1L	RAET1L	**SCN8A**	TAF1	UTRN
AHCY	C1QTNF6	CPAMD8	EDEM1	G3BP1	**HNRNPU**	LRP4	NEDD4L	PHF21A	RALGAPB	SCYL1	TAS2R4	VPS37A
AKAP6	C3orf22	CR2	EMILIN3	GABBR2	HRG	LUC7L3	NEDD9	PHIP	RALGPS1	SDCBP2	TCF4	WDFY2
AKR1C4	C4orf37	CREBBP	EPHB1	**GABRA1**	HSF2	MAML3	NETO2	PIGS	RANBP17	SELRC1	TCTE3	WDR1
ALG13	C5orf22	CRTAC1	ERG	GABRB1	HSPG2	MAN1A2	NFASC	PIK3AP1	RANGAP1	SERPINC1	TEP1	WDR19
ALMS1	C6orf222	CSMD2	ETNK2	**GABRB3**	IFT172	MAP3K8	NFE2L1	PIKFYVE	RARS	SETX	TET3	WDR45
ALS2CL	**CACNA1A**	CSNK1E	ETS1	GAS2	IQSEC2	MAPK8IP1	NFRKB	PITX1	RASIP1	SGK223	TEX15	WDR82
ANK3	CACNA1E	CTTNBP2NL	EXOSC2	GCM2	ITGAM	MAST1	NIPA1	PLA1A	RBM12	SKA3	THAP4	WHSC1L1
ANKRD12	CAMK4	CUBN	EXPH5	GFM2	ITGB4	MCM3	NLGN2	PLCG2	RBM45	SLAMF1	THOC2	WRN
ANKRD24	CANT1	CUL2	FAM102A	GLB1L3	ITPR1	MCM7	NLRP11	PLXNA1	RCL1	SLC16A3	TIFA	XPO1
ANKRD50	CASP14	CUX2	FAM116B	GLIS3	**KCNB1**	MEOX2	NLRP5	PLXNB1	RD3	**SLC1A2**	TMPRSS5	YPEL4
AP3S2	CASP9	CXXC11	FAM133B	GLUL	**KCNQ2**	MIOX	NLRP8	PNMAL1	RET	SLC25A13	TNKS2	YWHAG
ARFGEF1	CASQ1	CYP2U1	FAM134A	**GNAO1**	KCNQ3	MKLN1	NOLC1	PPP1R3B	RFX3	SLC26A11	TNNI3K	ZBTB40
ARRDC1	CCDC125	DAO	FAM21C	GPR108	**KCNT1**	MLL	NOTUM	PPP3CA	RGS14	SLC26A8	TPTE2	ZC3H3
ASH1L	CDC25B	DBP	FAM50A	GPR128	KDR	MLL2	NPAT	PPP6R2	RHOG	**SLC35A2**	TRIM29	ZFHX3
ASXL1	CDHR2	DCX	FAM63B	GPR98	KIAA0913	MMP27	NR1H2	PRDM12	RIOK3	SLC5A10	TRIM32	ZNF248
ATAD2B	**CDKL5**	DDX50	FAM86C1	GRAMD2	KIAA1324L	MRS2	NTSR2	PRDM4	RNF186	SLCO1B7	TRIM8	ZNF282
ATIC	CDS2	DDX58	FARSA	**GRIN1**	KIAA2018	MSANTD1	OR10S1	PRG3	RP1L1	SMG9	TRIO	ZNF354C
ATP2B4	CELA3B	DECR2	FASN	**GRIN2B**	KLHL11	MTOR	OR2F2	PRKX	RRP1B	SMURF1	TRRAP	ZNF572
B3GNT4	CELSR1	DHDDS	FBXL4	GTF2B	KMT2B	MTRF1	OR52E8	PRR19	RTKN2	SNX30	TSNAXIP1	ZNF839
BCL2L13	CEP55	DHTKD1	FBXO41	HBS1L	KNDC1	MVK	OSBPL5	PSD3	RTN1	SORBS3	TSPYL1	ZNFX1
BCLAF1	**CHD2**	DIAPH3	FCGR2B	HCK	KRT34	MYH6	OSBPL7	PTEN	RTP1	SP2	TTC16	ZSCAN2
BEST2		DIP2B	FERMT3	HCN4	KRTAP1-3	MYO3A	OXA1L	PTK2B	RUVBL2	SPG7	TTF1	ZSCAN21

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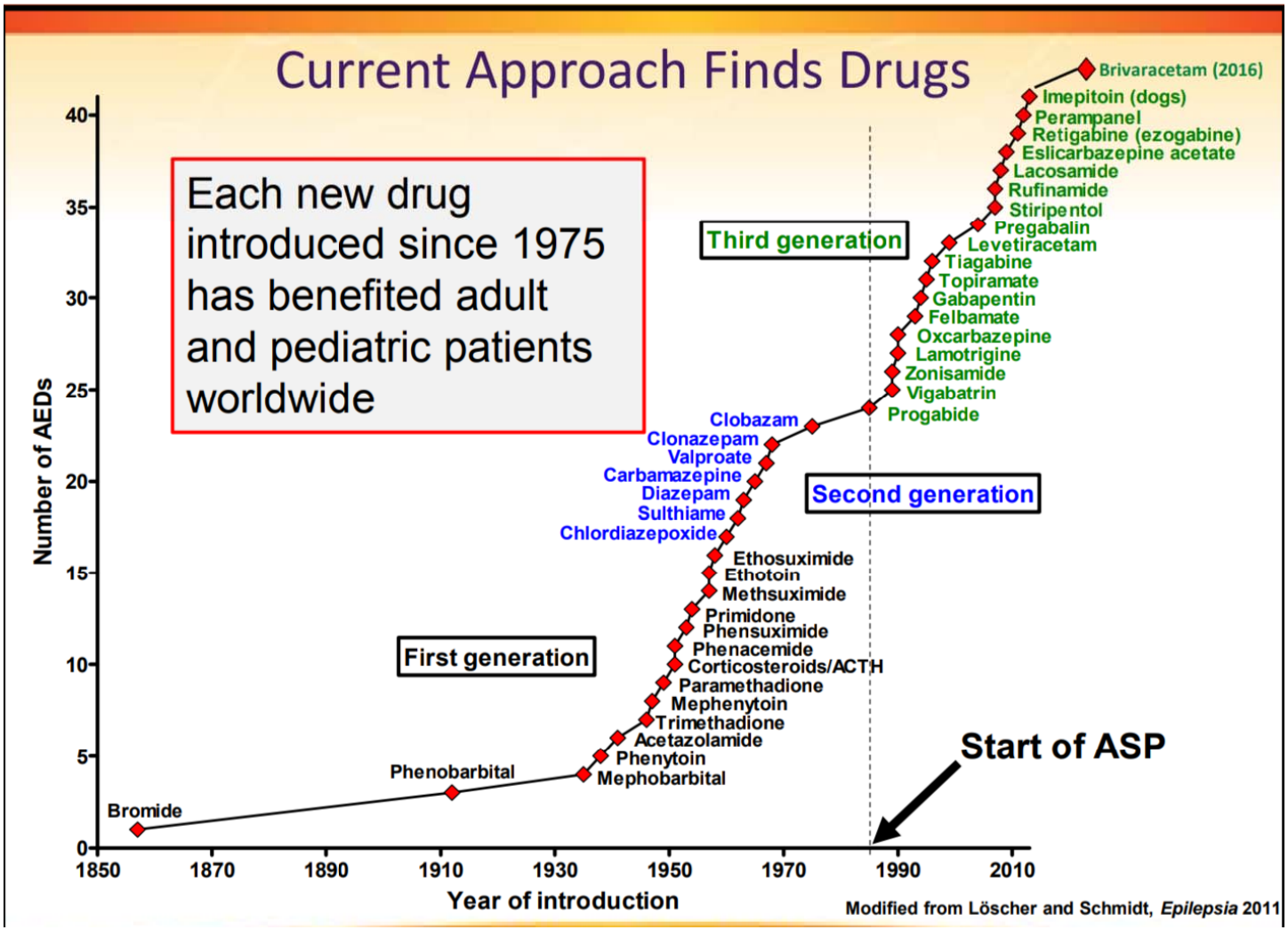
Epilepsia : Tratamiento



Epilepsia: Tratamiento

	1ra. Elección	2da. Elección	Otras opciones
Epilepsias Focales	OXC O CBZ	VPA	CLB-LVT-LCS-ESCBZ
Epilepsias Generalizadas			
Ausencias	VPA	ESM	LTG-BZP
Epilepsias Mioclónicas	VPA	LTG	CLB-TPM-ZNS
EMJ	VPA-LVT	LTG	TPM-CZP
Síndrome de Lennox Gastaut	VPA	LMT	ESM-CLB-RFM-TPM-DC
Epilepsia Mioclónico astática	VPA	ETM-CLB-LMT	DC-LVT-SLT-EV
Epilepsia con CTCG	VPA	LMT	LVT-TPM-CLB
Espasmos Epilépticos	VGB	ACTH	Piridoxina-AVP-TMP-DC

Respuesta a DAE en una población pediátrica argentina aplicando los nuevos conceptos de clasificación de Epilepsia (Guzman A. y cols. 2018.)

- **Objetivo:** Analizar la respuesta a DAE utilizando la nueva clasificación de epilepsia y síndromes epilépticos de ILAE

- **Material y Métodos:** Estudio descriptivo y prospectivo. 487 pacientes evaluados con epilepsia en el Hospital Público Materno Infantil (HPMI), desde 1 de agosto del 2016-30 de marzo del 2018.
- Se dividió en G1: síndromes epilépticos fármaco-sensibles, G2: epilepsias no sindromáticas fármaco-sensibles, G3: síndromes epilépticos resistentes a drogas y G4: epilepsias no sindromáticas resistentes a drogas. Se evaluaron DAE utilizados

- **Resultados:** 487 pacientes cumplieron criterios de Epilepsia y se definió sensibilidad a drogas.

Tratamiento

SENSIBLE n°(%)	RESISTENTE n° (%)
326 (66,9)	161(33,1)
44 m	23 m
6a8m	6a3m

Grupo 1
Síndromes epilépticos
57%

Grupo 2
No SE
43%

Drogas antiepilépticas utilizadas en Monoterapia

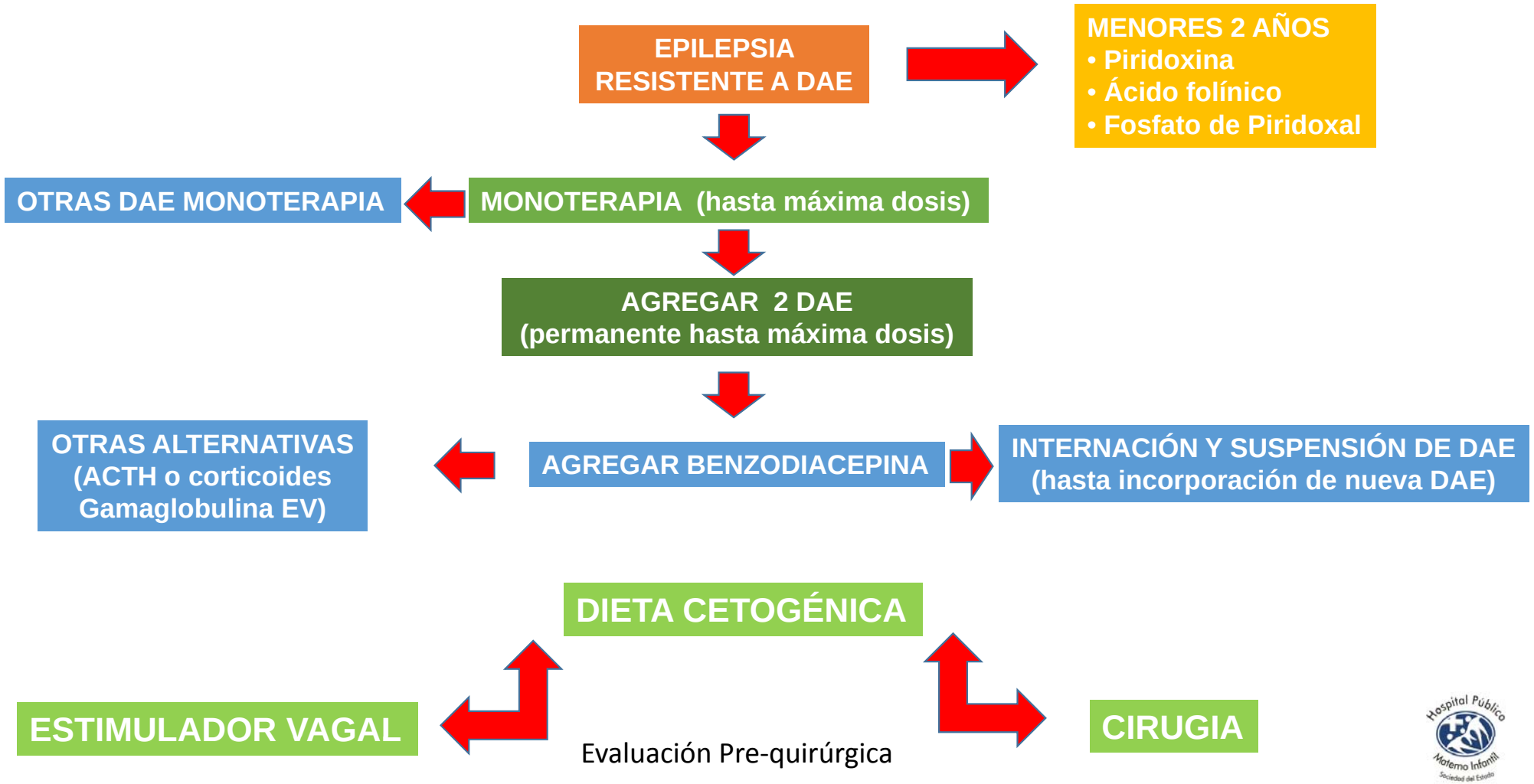
- 1ra generación:
- Fenobarbital: 33 (10.12%)
  - Epilepsia inicio 1er año de vida no EE: 25/52 (48%)

- 2da generación
- Acido Valproico: 137/326 (42%)
  - Epilepsias sindromáticas: 68/186 (36,5%)
    - Focales: 36/114 (31%)
    - Generalizadas 31/43 (72%)
  - Epilepsias no sindromáticas 69/140 (49%)
    - Focales: 56/120 (46,5%)
    - Generalizadas: 13/20 (65%)

Drogas antiepilépticas utilizadas en Monoterapia:

- Clobazam (CLB) 17 (5.2%)
  - EBI-R: 9/28 (32%)
- Carbamazepina (CBZ) 16 (4.9%)

- 3ra generación
- Oxcarbazepina (OXC) 23 (7.05%)
- Levetiracetam 6 (1.8%)
- Vigabatrina 3 (0.9%)
- Topiramato 2 (0.6%)



Adaptado de Caraballo y Fejerman, 2009

Epilepsia: Dieta Cetogénica

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Long-term follow-up of the ketogenic diet for refractory epilepsy: Multicenter Argentinean experience in 216 pediatric patients

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Table 1
Types of epilepsy or epileptic syndrome found in 212 patients with refractory epilepsy treated with the KD.

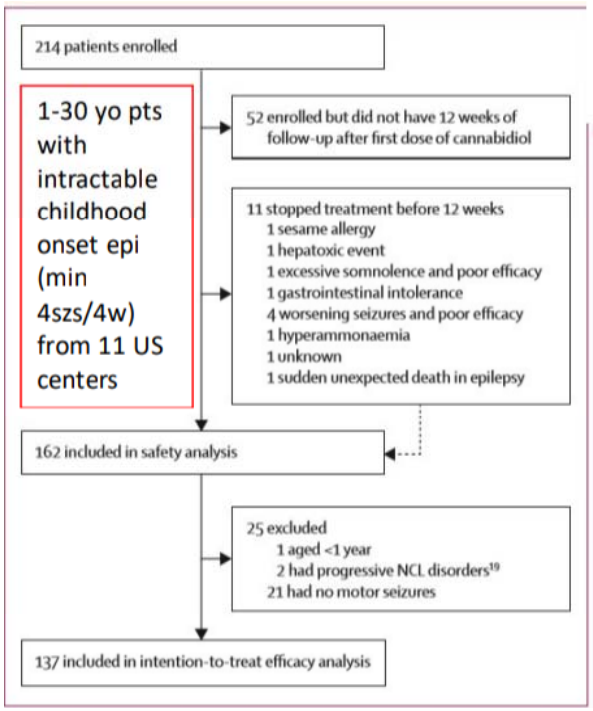
Type of epilepsy and epileptic syndrome	Etiology	Number of patients
Symptomatic focal epilepsy	Cortical dysplasia	20
	Tuberous sclerosis	13
	Encephalitis	18
	Hypoxic–ischemic encephalopathy	11
	Porencephalic cyst	3
	Vascular malformations	4
Epilepsy with myoclonic-astatic seizures		38
Cryptogenic Lennox–Gastaut syndrome		7
Symptomatic Lennox–Gastaut syndrome	Encephalitis	6
	Cortical dysplasia	10
	Chromosomal abnormalities	4
	Neonatal hypoglycemia	3
	Hypoxic–ischemic encephalopathy	2
Cryptogenic West syndrome		8
Symptomatic West syndrome	Hypoxic–ischemic encephalopathy	4
	Porencephalic cyst	4
	Cortical dysplasia	5
	Aicardi syndrome	2
	Tuberous sclerosis complex	2
	Septo-optic dysplasia	1
	Meningitis	1
	Encephalitis	1
Dravet syndrome		32
Cryptogenic epileptic encephalopathy with CSWSS		3
Symptomatic epileptic encephalopathy with CSWSS	Unilateral polymicrogyria	2
Fever-induced refractory epileptic encephalopathy		5
Epilepsy with myoclonic absences		2
Migrating focal seizures in infancy		1

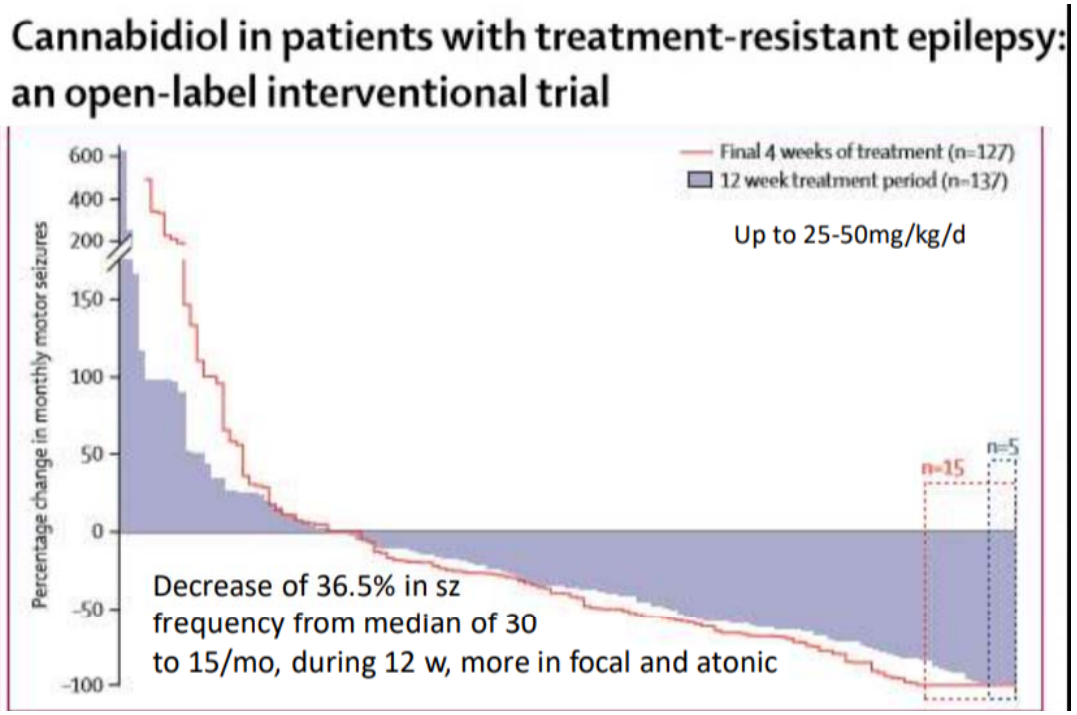
2

PERSISTEN EN DC A LOS 18m DE INICIO: 216/140 (65%)

- LC 31/140 (22%)
- REDUCCION 75-99% 50 (36%)
- REDUCCION 50-74% 14 (10%)
- REDUCCION MENOR 50% 47 (33,5%)
- 20 LC DEJARON LA DC.
- RECURRIERON LAS CRISIS EN 5 (25%)

Epilepsia: eficacia de Cannabis





- 39% reducción del mayor o igual 50% (respondedores)
- 32 pacientes con Síndrome de Dravet (49,8%) reducción mayor o igual al 50%
- 30 pacientes con Síndrome de Lennox Gastaut (36.7%) respondedores

Devinsky, Lancet Neurol 2015

Epilepsia: eficacia de Cannabis

- 74 pacientes (88% dishabilidad intelectual)
- Reducción crisis:

75-100% 18%

50-75% 34%

25-50% 12%

Menos 25%: 26%

Libre de crisis 1

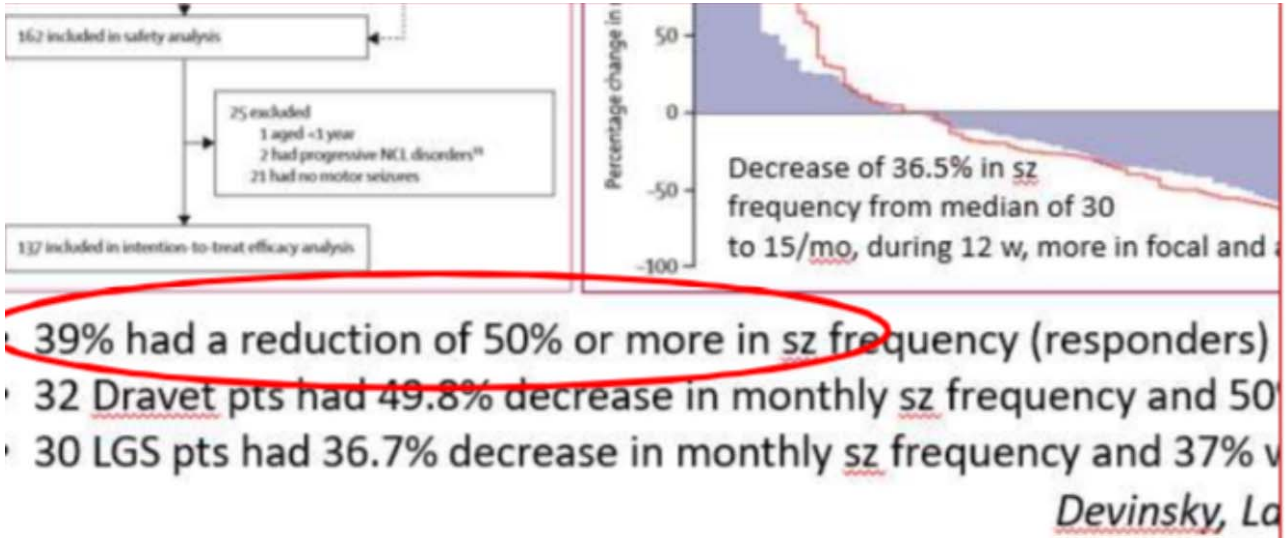
60% otros beneficios: mejoría comportamiento, estado de alerta, lenguaje, comunicación, habilidades motoras y sueño

EA
- **Agravamiento de crisis**
- **somnolencia**
- **Fatiga**
- **T. Gastrointestinales**
- **Irritabilidad**

Tzadok, Seizure 2016

Eficacia de Canabinoides en Epilepsia

- Eslicarbazepina 33,9%
- Restigabine 34,9%
- Carisbamate 25,9%
- Lacosamida 38,1%
- Brimaracetan 43 %
- Parampanel 33%
- 15 estudios en total 32,5%%



Gao L. et al, Epi Research 2012

Conclusiones

- Definir si es una crisis epiléptica o no epiléptica
- Descartar una convulsión aguda sintomática ante una primera convulsión
- En caso de epilepsia definir, tipo de crisis, tipo de epilepsia, evaluar probable síndrome epiléptico y buscar la etiología
- Debemos hacer un adecuado análisis electro-clínico para hacer un adecuado diagnóstico de la epilepsia
- Debemos hacer un adecuado uso de las opciones terapéuticas y DAE
- En caso de Epilepsia resistente a DAE hay tratamientos alternativos que han demostrado un efecto beneficioso para estos pacientes

Muchas Gracias…