Fits, Faints and Funny Turns

<u>Background</u>

Epilepsy affects 1 in 200 children

Diagnosis is largely based on the history

Rate of misdiagnosis still high

A clear description of the episode is key

<u>History</u>

what activity was he/she doing
what happened first?
Was the movement repetitive or sustained?
Any colour change?
How long it lasted ?
Could it be interrupted ?
how long to full recovery?
Chest pain / palpitations?

<u>Examination</u>

- full neurological exam
- measure head size
- neuro-cutaneous stigmata (eg café au lait)

Investigations

neuro-imaging (MRI) if <

History all important

judicious use of EEG

2yo or focal seizures

blood sugar

vital signs

Background Camera/mobil

e phone video by parents has greatly enhanced our ability to make an accurate diagnosis

Febrile seizures

6m-6years

1 in 20

Fever>38.5

Most simple

Recurrence up if : Delayed / complex first seizure / Family history

Parental education important

References

Paediatrics and

Child Health

2009;19:

199-235

Treatment

antiepileptic medication should usually be started after the second unprovoked seizure

TAKE HOME MESSAGES

The history of an attack is key to diagnosis

Misdiagnosis is quite common

Be aware of differentials

Consider ECG (prolonged QT and WPW)

Differentials

benign sleep myoclonus / shuddering / selfgratification in infancy

Febrile seizures Reflex anoxic seizures Breath -holding Night terrors Vasovagal syncope Migraine Pseudo-seizures Long Q-T

Summary

Epilepsy is a clinical diagnosis with many differentials. Diagnosis rest on the history <u>not</u> the EEG This algorithm has been produced by the National Paediatric and Neonatology Clinical Programmes. It is aimed at medical, nursing and allied health professionals working in both primary and emergency care settings. Amendments following suggestions of QIP

committee of ICGP . Secondary care denoted in pink

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