Guidelines You Can Sink Your Teeth Into

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Providers who work with seizure patients on a daily basis can forget how profoundly distressing and life changing a first unprovoked seizure can be. Particularly for otherwise healthy patients, an unprovoked seizure is an abrupt detour from normalcy to uncertainty. After “what happened?” comes “what does the future hold?”

There is possibly some solace in the fact that many others have been in the same situation. In addition to whatever emotional comfort this might bring, it also means that there is substantial accumulated clinical experience and data to bear on prognosis and therapeutic decision making. An experienced neurologist, internist, or emergency room physician will likely have seen and advised many patients in this situation but will still have a limited breadth of personal experience.

This is, of course, where clinical guidelines may often play a role, by extending the clinician's own experience to include the larger published clinical experience. The authors of evidence-based guidelines systematically identify pertinent studies from the literature, judge their relevance, assess them for level of evidence and risk of bias, synthesize the findings, and produce recommendations with varying level of certainty. Critics of guidelines and evidence-based medicine sometimes complain that the limits of clinical evidence may result in tepid guidelines that provide little practical guidance to the clinician. For example, an elegantly conducted Cochrane review of yoga as a treatment for epilepsy runs 42 pages and concludes that “no reliable conclusions can be drawn regarding the efficacy of yoga as a treatment for uncontrolled epilepsy.”⁽¹⁾ These reviews point to areas in need of further high-quality studies and provide a framework to integrate those studies into the existing guideline process but may not provide practical answers to clinical questions.

The clinical guidelines for management of first unprovoked seizures in adults should not face this criticism. On the contrary, the available evidence is of sufficient quantity and quality to address some of the primary concerns of individuals with a first unprovoked seizure and the clinicians caring for them. *Evaluation* of a first unprovoked seizure is addressed in a previous practice guideline ⁽²⁾. For *management* of a first unprovoked seizure, the critical determination in this situation is an assessment of the risk of seizure recur-

rence. The guidelines direct that patients can be informed that the greatest risk of recurrence is early, in the first 2 years. They make relatively strong statements about the predictive power of EEG, imaging, presence of a prior brain insult, and nocturnal onset in determining risk of recurrence; though there are still remaining questions about whether these individual risks are additive. The guidelines address several important issues surrounding antiepileptic drug (AED) therapy, including short and longer term influences on prognosis and effects on quality of life. Data are summarized on the frequency and severity of adverse effects from AED therapy.

Critics of evidence-based medicine still might maintain that some of the recommendations in these guidelines are based on lower levels of evidence and that evidence from high-quality studies does not exist for all aspects of management of the patient with a first unprovoked seizure.

In this case, however, those criticisms would ring hollow. Evidence-based guidelines were never intended to replace clinical judgment. Rather, they are most useful when they provide a foundation on which sound clinical decision making can be built. There will always be an art to medicine, but the art does not lie in a clinician guiding patients based solely on his narrow experience in similar cases or on what he was taught by trusted mentors. Instead, the art lies in reassuring patients that they will be supported with good information about what to expect and in making good decisions about what to do next. This support comes from the science that resides in the clinical literature and that is distilled in clinical guidelines. It comes from the clinician's knowledge of the patient's needs and skill in applying the compiled clinical knowledge to that patient's unique situation. For the patient with a first unprovoked seizure, these guidelines provide the necessary foundation. They are guidelines you can sink your teeth into.

References

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