Suppressed circadian heart rate dynamics in temporal lobe epilepsy


Objectives: To measure interictal circadian rhythm of heart rate (HR) variability in patients with temporal lobe epilepsy (TLE) using a 24 hour ECG recording.

Methods: Various conventional and dynamic fractal measures of HR variability were analysed in 17 patients with refractory TLE, 20 patients with well controlled TLE, and 37 healthy age and sex matched control subjects.

Results: The SD of all RR intervals (p<0.01), the measured power spectral components of HR variability (low frequency power (p<0.01), high frequency power (p<0.05)), and the SD1 (p<0.05) and SD2 (p<0.01) Poincaré two dimensional vector analysis measurements were suppressed in the patients. This suppression was observed during both day and night time; however, it was more pronounced at night, and nocturnal increase in HR variability usually seen in the normal population could not be detected in the patients. The HR variability measures did not correlate with the duration of epilepsy, the age of the patients, or with the anti-epileptic drugs used.

Conclusion: TLE was associated with reduced HR variability, which was more pronounced during night than day, and the nocturnal increase in HR variability was abolished in patients with TLE. The alteration in autonomic regulation of HR variability was similar in patients with both refractory and well controlled TLE.

Materials and methods

Patients and controls

This was a post hoc re-analysis of data from a previously published study.24 Seven patients were excluded from the re-analysis owing to technical problems. The study was carried out in the Department of Neurology, University Hospital of Oulu, Finland, with the approval of the local ethics committee. All the patients and control subjects gave their informed consent before their inclusion in the study.

There were 37 TLE patients, who had been seen in the outpatient clinic, included in the study. The study group consisted of 17 patients with refractory TLE who continued to have seizures (mean (SD) seizures/month 20.3 (38.2)), despite the appropriate use of anti-epileptic drugs (AEDs), and who were not suitable candidates for epilepsy surgery or other newer epilepsy therapies. Of the 20 patients with well controlled TLE, 16 had become seizure free after starting AED treatment, and four had fewer than two seizures per year. Patients with any other disease (such as diabetes mellitus, alcoholism, or cardiopulmonary disease), manifestations of other central or peripheral nervous system disorders, or medication (other than AEDs) known to affect the autonomic nervous system were excluded from the study. Women who were pregnant or lactating were also excluded. Various cerebral lesions are known to decrease HR variability, therefore, to exclude symptomatic epilepsy, magnetic resonance imaging of the brain was performed on all the patients, except three patients with well controlled TLE who suffered from clausrophobia, on whom computed tomography of the brain was performed. Three patients had left hippocampal sclerosis, and two had right hippocampal sclerosis. All the other patients had normal imaging of the brain. The excluded patients' affiliations

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Epileptic seizures may be associated with autonomic dysregulation manifesting, for example, as blood pressure (BP) and heart rate (HR) changes. Moreover, there is increasing evidence of inter-ictal autonomic nervous system dysfunction in patients with temporal lobe epilepsy (TLE). An association of the occurrence of autonomic dysfunction with life threatening arrhythmias in patients with epilepsy and even with sudden unexpected death in epilepsy (SUDEP) has been suggested, but the clinical significance of autonomic dysfunction in patients with epilepsy is still poorly outlined.

SUDEP is a widely recognised phenomenon, but its basic mechanism remains unclear. Previous studies have defined a number of risk factors that are associated with SUDEP, but otherwise healthy, compliant patients may also die unexpectedly. Hypoventilation and cardiac changes occurring during or immediately after a seizure have also been connected with SUDEP. Furthermore, some studies imply that SUDEP usually occurs during sleep, suggesting that circadian rhythms may contribute to its pathogenesis.

Circadian rhythms are endogenously mediated 24 hour cycles of behavioural or physiological activity, but the interactions that occur between the mammalian circadian clock, acute seizures, and chronic epilepsy have so far not been characterised. Earlier studies observed a decreased circadian HR fluctuation in several cardiovascular and neurological diseases, and after an acute myocardial infarct it seems to be related to lethal cardiac arrhythmic events. The circadian rhythms of autonomic cardiovascular functions have not been previously evaluated in TLE, although it is known that patients with epilepsy often have nocturnal seizures.

The hypothesis of the present study was that HR variability is lower in patients with TLE during the night than during the day, reflecting a suppression of circadian dynamics. This study was designed to assess the circadian rhythm of HR variability in patients with TLE using a 24 hour ECG recording.

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Abbreviations: AED, anti-epileptic drug; ApEn, approximate entropy; BP, blood pressure; HF, high frequency; HR, heart rate; LF, low frequency; SUDEP, sudden unexpected death in epilepsy; TLE, temporal lobe epilepsy; VLF, very low frequency
patients were more often men than women and, as a result, the present study included more women than men.

Patients were carefully interviewed and clinically examined. Their epilepsy and seizure types were classified according to the recommendations of the International League Against Epilepsy. All patients had TLE. Thirteen patients with refractory and 16 with well controlled TLE had secondarily generalised seizures. Three patients with refractory and two patients with well controlled TLE had complex partial seizures, while one with refractory and two with well controlled TLE had simple partial seizures.

Results of laboratory tests (liver and renal functions, serum electrolytes, and basic haematological indices) were normal. Serum AED levels within the therapeutic range in all patients. Blood samples for the laboratory tests were taken in the morning before the 24 hour ECG recording.

An interictal EEG recording was obtained from all the patients. Normal EEG or general slowing was seen in 15 patients. Left temporal focal slow waves, or irritation, or both were detected in 15 patients, and right temporal focal abnormalities were seen in seven.

The control group consisted of 37 healthy age and sex matched subjects selected from healthy individuals participating in a study comparing the characteristics of hypertensive and normotensive subjects, who were randomly selected by personal social security codes from the general population of the local community. All were carefully examined and had no medication or other disease affecting the autonomic nervous system in their medical history. The demographic data of the patients and controls are given in table 1.

### Methods
A two channel, 24 hour ambulatory ECG recording (Del Mar CardioCorder, model 456A; Del Mar Medical, Irvine, CA, USA) was performed once on all the patients and controls. During recording, patients and controls were allowed to perform their daily activities. They also kept a diary to document seizures and abnormal events during the recording.

The ECG data was sampled digitally and transferred from an Oxford Medilog scanner (Oxford Instruments, Oxford, UK) to a microcomputer for analysis of HR variability. All the RR intervals were passed through a filter using previously described methods.

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### Table 1: Demographics of the study patients and controls

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patients with TLE</th>
<th>Controls</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Refractory (n = 17)</td>
<td>Well controlled (n = 20)</td>
<td>n = 37</td>
</tr>
<tr>
<td>Age (years, mean (SD))</td>
<td>32.1 (7.2)</td>
<td>32.2 (6.6)</td>
<td>32.2 (8.3)</td>
</tr>
<tr>
<td>Men/women</td>
<td>4/13</td>
<td>9/11</td>
<td>13/24</td>
</tr>
<tr>
<td>Duration of TLE (years, mean (SD))</td>
<td>22.7 (10.0)</td>
<td>14.2 (10.1)</td>
<td>13.2 (2.4)</td>
</tr>
<tr>
<td>Seizure characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure free (no. of patients)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure per month (mean (SD))</td>
<td>20.3 (38.2)</td>
<td>0.03 (0.07)</td>
<td></td>
</tr>
<tr>
<td>Antiepileptic medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxcarbazepine</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenytoin</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polytherapy</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBL with other AED(s)</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXC with other</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AED(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AED, anti-epileptic drug; CBL, carbamazepine; OXC, oxcarbazepine.

### Statistical analysis
The data were analysed using the SPSS software (version 10.0; SPSS Inc. Chicago, IL, USA). Statistical analysis was performed using the Mann-Whitney two sample test to compare the values of the controls and those of the patients, and to compare the day and night values. Spearman’s correlation coefficients were used to estimate the correlation of the HR variability during night and day with the duration of TLE and the age of the patients. In all cases p<0.05 was considered significant. The Mann-Whitney two sample test was used to analyse the association of HR variability with the laterality of the seizure focus.
RESULTS
The mean values for the various measures of HR variability for the 24 hour ECG recordings of the patients with refractory and well controlled TLE and the controls are presented in table 2. The night and day values are presented separately. During the night, the SDNN (p = 0.001), the spectral components LF (p = 0.001) and HF (p = 0.004), the SD1 (p = 0.001) and SD2 (p = 0.001) Poincaré components and the short term fractal property parameter α (p = 0.01) of the patients were significantly lower than those of the controls (table 2). Similarly, during the day, SDNN (p = 0.001), the spectral components LF (p = 0.001) and HF (p = 0.036) and the SD1 (p = 0.022) and SD2 (p = 0.001) Poincaré components were decreased in the patients compared with the controls. ApEn showed no differences in any group during either the night or day. The mean RR interval value showed no difference between study groups.

The SDNN, the spectral components LF and HF, and the SD1 and SD2 Poincaré components were lower (p < 0.05) in the well controlled and refractory patients with TLE than in the controls when compared separately. There were no differences in any HR variability measurements (p > 0.05), apart from ApEn in the night (p = 0.026), between the patients with refractory and those with well controlled TLE when compared with each other.

Fig 1 shows the suppression of the circadian fluctuation of the HF and LF spectral components in TLE patients compared with the healthy controls. The LF value of the patients was decreased throughout the 24 hour recording time. Similarly, the HF value was significantly lower in the patients than in the controls during the day, but the difference was more pronounced during the night. The nocturnal increase in HF and LF spectral components that was seen in the controls could not be detected in the patients.

The mean night to day ratios of the SDNN (fig 2), SD1, and SD2 Poincaré components were lower in the patients (median, interquartile range): SDNN 0.80, 0.68 to 1.07, p = 0.014; SD1 1.16, 0.98 to 1.44, p = 0.030; SD2 0.78, 0.62 to 0.92, p = 0.007) than in the controls (SDNN 1.07, 0.90 to 1.17; SD1 1.48, 1.07 to 1.70; SD2 0.98, 0.74 to 0.97). There were no differences in the mean night to day ratios in the spectral components LF and HF, ApEn, and the short term fractal property component α (p > 0.05) between patients and controls. Furthermore, none of the night to day ratios of the HR variability measures were different between the patients with refractory and those with well controlled TLE (p > 0.05).

None of the patients or controls had cardiac arrhythmias or other clinically significant ECG abnormalities during the recording. Six of the patients with refractory TLE reported having a partial seizure during the 24 hour ECG recording. Analysis of HR variability of these patients showed no

Table 2 The night and daytime values for the time domain, frequency domain, and fractal measures of HR variability in patients with temporal lobe epilepsy and in the controls

<table>
<thead>
<tr>
<th>Night</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>RR interval (ms)</td>
<td>1000</td>
</tr>
<tr>
<td>SDNN (ms)</td>
<td>926 to 1072</td>
</tr>
<tr>
<td>LF (ms x ms)</td>
<td>412 to 1000</td>
</tr>
<tr>
<td>HF (ms x ms)</td>
<td>474</td>
</tr>
<tr>
<td>SD1</td>
<td>26</td>
</tr>
<tr>
<td>SD2</td>
<td>86</td>
</tr>
<tr>
<td>α</td>
<td>1.04</td>
</tr>
</tbody>
</table>

Night = 0000–0600; day = 0900–2100. SDNN, SD of all RR intervals; LF, low frequency; HF, high frequency; SD1, beat to beat variability measure from Poincaré; SD2, long term variability measure from Poincaré; α, short term fractal correlation parameter; ApEn, approximate entropy. Values are presented as medians (interquartile range). *p < 0.05; **p < 0.01; ***p < 0.001 compared with controls, Mann-Whitney U test.
differences compared with the analysis of HR variability of patients without seizures.

Altered circadian HR variability during the night or day did not correlate significantly with the duration of TLE, the AEDs used, or the age of the patients. There was also no correlation with altered circadian HR variability and the side of the seizure focus (p>0.05).

**DISCUSSION**

HR variability was decreased, and physiological circadian fluctuation almost abolished, in patients with TLE. In particular, the LF and HF power spectral components and the SD1 and SD2 measures of Poincaré analysis were lower in the patients than in the healthy controls. The altered rhythm of circadian HR variability did not correlate with the duration of TLE or the age of the patients.

Previous studies have reported diminished interictal HR variability in TLE patients using conventional short and long term ECG recordings, but the clinical significance of the findings has remained unclear. The findings of the previous analysis of HR variability in the present patients suggest that in TLE, diminished HR variability is due to the epileptic process itself, rather than to any specific AED regimen, contrary reports have been published. There are no previous reports focusing on the circadian rhythm of HR variability in epilepsy. In the present study, the decreased circadian HR variability did not correlate with the duration of TLE or the age of the patients, nor was it associated with any specific AED regimen. However, all patients were taking AEDs that block voltage dependent sodium channels, and, therefore, it was difficult to assess the effects of different types of AEDs on cardiovascular autonomic regulation.

Moreover, the changes were seen in both patients with refractory and those with well controlled TLE. Therefore it seems that cardiovascular dysregulation is associated with TLE itself regardless of its duration or severity.

In general, low HR variability is often associated with sudden arrhythmic death, but recent studies have suggested that low HR variability also predicts non-arrhythmic cardiac events. However, different study designs and patient populations make it difficult to compare the results of the different studies. Reduction of circadian HR fluctuation has been reported in various cardiovascular and neurological diseases, including stroke, diabetes mellitus, coronary artery disease, hypertension, and recently Parkinson’s disease. After an acute myocardial infarct, suppressed circadian fluctuation seems to be related to lethal arrhythmic events. In a recent study, abnormal long term HR dynamics predicted post-stroke mortality. Furthermore, a previous study with a random sample of 325 subjects followed up for 10 years showed that an altered short term fractal scaling exponent of HR dynamics indicated an increased risk for cardiac mortality, particularly sudden cardiac death.

Circadian rhythms are endogenously mediated biological rhythms with a cyclic period of about 24 hours. The suprachiasmatic nucleus of the hypothalamus is thought to be the major component of the mammalian circadian timing system controlling the circadian changes. The insular cortex, on the other hand, is considered involved in cardiovascular regulation and has wide connections to other cortical and subcortical cardiovascular autonomic controlling centres.

In TLE, seizures arise from the mesial temporal structures—that is, the amygdala and hippocampus, or neocortical regions, and damage in those areas may result in abnormalities manifested by the attenuation of circadian rhythms. The design of the present study did not allow the drawing of any conclusion about the possible association of damage to specific temporal lobe structures with the observed changes in autonomic cardiovascular control.

SUDEP is more common in refractory epilepsy, but otherwise healthy, compliant patients may also die unexpectedly. Moreover, SUDEP has been noted to be prevalent both in idiopathic generalised epilepsy and in TLE. We included both refractory and well controlled patients in the present study. However, only TLE patients were included to make the study population more homogenous and to allow a meaningful comparison between the patients with epilepsy and the controls.

A large body of data has defined different risk factors for SUDEP, including low AED serum concentration, a high number of AEDs taken concomitantly, male sex, a long duration of epilepsy, and number of epileptic seizures per year, but its basic mechanism is not yet understood. Some studies have suggested that SUDEP is caused by cardiovascular autonomic dysfunction, which exposes the patient to arrhythmias, sinus arrest, and neurogenic pulmonary oedema. Abnormalities of nocturnal HR variability are particularly interesting, because SUDEP has been observed to occur usually during sleep. Previous studies suggest that suppressed nocturnal vagal activity is an unfavourable phenomenon, particularly in coronary artery disease, leading to unopposed sympathetic activity and an imbalance between the sympathetic and parasympathetic cardiovascular autonomic regulatory systems.

Interestingly, the present study showed that suppression of HR variability in TLE is most pronounced at night, suggesting a night time parasympathetic dysfunction for patients with epilepsy. None of the above risk factors was associated with significant difference in HR variability in this study. This suggests that impaired circadian HR variability is one of the risk factors for, but not the direct cause of SUDEP. Consistent with this, a recent study suggested that nocturnal suppression of HR variability in patients with epilepsy may contribute to the risk of SUDEP during the night.

The present observation that suppressed circadian HR variability was also present in patients with well controlled TLE is in accordance with the concept that healthy, compliant patients with epilepsy may also die unexpectedly. Additional prospective studies are needed to evaluate the association between SUDEP and the impaired circadian HR variability in TLE and in other types of epilepsies.

Earlier studies have suggested that carbamazepine may decrease HR variability. Recently, it was demonstrated in a prospective study that carbamazepine may suppress both parasympathetic and sympathetic functions in newly
diagnosed epilepsy. Interestingly, in that study the circadian HR fluctuation appeared to be already decreased before carbamazepine treatment, and after starting carbamazepine the HR variability suppression was more pronounced both in day time and night time. This suggests that epilepsy itself may be associated with circadian cardiovagal dysregulation. In the present study, we did not find any association between the AED medication used and the diminished circadian cardiovagal regulation. However, the number of patients in the present study was small, and all patients were taking voltage-dependent sodium channel blockers without other AEDs. Therefore, the effect of different types of AEDs on suppressed circadian HR variability is difficult to assess in the present study.

In conclusion, TLE is associated with diminished HR variability. This diminution is more pronounced during the night than during the day, reflecting depressed physiological circadian HR fluctuation. In fact, the nocturnal increase in HR variability usually seen in the normal population could not be detected in patients with TLE. There were no differences in HR variability between patients with well controlled and those with refractory TLE. Therefore, the reduction in HR variability and in its circadian fluctuation seems to be associated with TLE itself, not with the duration or severity of the condition.

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REFERENCES
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