Sudden unexpected death in epilepsy (SUDEP): don’t ask, don’t tell?

B Morton, A Richardson, S Duncan

Methods: We conducted a survey of current practice among UK neurologists, using a questionnaire sent to all practising neurologists in the UK listed on the Association of British Neurologists database, asking under what circumstances they told patients about SUDEP. Results: Of the validated respondents, 5% discussed SUDEP with all patients, 26% with a majority, 61% with a few, and 7.5% with none. The commonest reasons for SUDEP to be discussed were the patient asking about it and the neurologist counselling people with known risk factors for SUDEP.

Conclusions: The variation we found, although not necessarily in tune with the guidelines, reflects the variation in patients’ need for knowledge about their condition.

Background: The National Institute for Clinical Excellence in the UK has issued guidelines stating all individuals with epilepsy be given information about sudden unexpected death in epilepsy (SUDEP). We sent a questionnaire to all practising neurologists in the UK listed on the Association of British Neurologists database, asking under what circumstances they told patients about SUDEP.

Results:

<table>
<thead>
<tr>
<th>Discuss SUDEP with all patients</th>
<th>18</th>
<th>4.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss with majority of patients</td>
<td>99</td>
<td>25.6</td>
</tr>
<tr>
<td>Discuss with very few of my patients</td>
<td>237</td>
<td>61.2</td>
</tr>
<tr>
<td>Discuss with none of my patients</td>
<td>29</td>
<td>7.5</td>
</tr>
<tr>
<td>Total no. of respondents</td>
<td>383</td>
<td>100</td>
</tr>
<tr>
<td>Missing data*</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

*Four responses not analysed.

Abbreviations: NICE, National Institute for Clinical Excellence; SIGN, Scottish Intercollegiate Guidelines Network; SpR, specialist registrar; SUDEP, sudden unexpected death in epilepsy.
thought patients did not understand the relative risks of SUDEP compared with smoking 20 cigarettes per day or the risk of developing lung or breast cancer. Interestingly, a majority reported they did not think informing patients about SUDEP improved drug compliance or to avoidance of risk factors for SUDEP.

Respondents who stated a special interest in epilepsy were significantly more likely to tell patients about SUDEP. Doctors who discussed SUDEP with all or the majority of their patients were significantly less likely to report negative reactions from patients than those who did not (table 1).

### Qualitative responses

Respondents were asked to record their experiences/opinions and suggestions about practise in this area (tables 4 and 5).

**Table 2** $\chi^2$ analysis of differences in practise between those neurologists with a special interest in epilepsy versus those without, and of differences in patient reactions as recorded by neurologists who tell the majority of patients about SUDEP versus those who tell the minority of patients

<table>
<thead>
<tr>
<th>Interest category</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special interest in epilepsy</td>
<td>49</td>
<td>69</td>
</tr>
<tr>
<td>No special interest in epilepsy</td>
<td>68</td>
<td>196</td>
</tr>
<tr>
<td>Total</td>
<td>117</td>
<td>264</td>
</tr>
</tbody>
</table>

$\chi^2 = 0.002$

<table>
<thead>
<tr>
<th>Patient reactions</th>
<th>Positive</th>
<th>Equanimity</th>
<th>Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>70</td>
<td>18</td>
<td>96</td>
</tr>
<tr>
<td>$\chi^2 = 0.001$</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*1 I tell all or the majority of my patients about SUDEP; 1 I tell some, few or none of my patients about SUDEP.

There were 299 respondents who wrote comments in the “how do patients react?” question box, of which 275 could be assigned to the “positively”, “with equanimity”, and “negatively” groups. The remainder were comments that could not be assigned, for example “difficult to tell”.

**DISCUSSION**

As 82% of consultant neurologists in the UK replied to our survey, we have obtained a representative picture of how neurologists practise in this area. Other specialties in the UK such as psychiatry and medicine for the elderly also care for people with epilepsy, and practice may be different in those fields.
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be told they could die because of epilepsy, then it would be information on SUDEP should be imparted. If patients are to appear that many neurologists were led by their clinical scenario were prompted most often by the patient SUDEP (16%). Those who discussed SUDEP in more than one commonest single scenario was if the patient asked about protecting their own emotional state. SUDEP because of a wish not to cause distress or as a way of reactions. Emotive terms such as “terrified”, “acute distress”, Neurologists who only discussed SUDEP in a minority of ease with the topic, or patients who have already heard about might be explained by a practice effect, with those significantly less likely to report negative reactions. This may reflect familiarity with NICE or the Scottish patient groups and the internet, but it implies that many neurologists do not feel this information is something all patients need to know. Neurologists with a special interest in epilepsy were statistically more likely to discuss SUDEP with patients. This may reflect familiarity with NICE or the Scottish Intercollegiate Guidelines Network (SIGN), the influence of patient advocacy groups, or a patient population that is more likely to ask about SUDEP. These neurologists were also significantly less likely to report negative reactions. This might be explained by a practice effect, with those neurologists who frequently discuss SUDEP being more at ease with the topic, or patients who have already heard about the phenomenon being prepared for the information. Neurologists who only discussed SUDEP in a minority of cases were significantly more likely to report negative reactions. Emotive terms such as “terrified”, “acute distress”, and “catastrophic” were used. Such reactions may have served to inhibit these doctors from frequent discussion of SUDEP because of a wish not to cause distress or as a way of protecting their own emotional state. Practitioners were equally divided between those who only discussed SUDEP in one of the clinical scenarios put to them and those who did so in more than one clinical situation. The commonest single scenario was if the patient asked about SUDEP (16%). Those who discussed SUDEP in more than one clinical scenario were prompted most often by the patient asking or a patient having risk factors for SUDEP (16%). It would appear that many neurologists were led by their patients’ request for information. NICE gives no guidance on how, when, and by whom information on SUDEP should be imparted. If patients are to be told they could die because of epilepsy, then it would be useful to put that risk in context. There is a striking lack in NICE/SIGN and the literature of league tables of relative risks to enable patients to see what their chances of succumbing to SUDEP are compared with a fatal road traffic accident, myocardial infarct, or common cancers. One recent paper has produced estimated years of lost life expectancy in a table format. A man aged 20 years with idiopathic epilepsy has, according to the authors, a 9 month reduction in life expectancy. Some would question what use this information would be to a patient. Another study concluded that as the main risk factors for SUDEP, such as male sex, need for polypharmacy, and having a localisation epilepsy are impossible to modify, information on SUDEP should be targeted at this group.

Medical opinion leaders and patient advocates maintain people must be given as much information as possible, and that guidelines will cover all medical contingencies. This stance denies the patient the right not to know,9 and undermines the physician’s ability to treat patients as individuals. One in depth examination of the information needs of patients with Parkinson’s disease7 identified three equally sized patient groups: “seekers”, who needed information and found ignorance unbearable; “weavers”, who incorporated information into their lives at their pace, often ignoring much of it; and “avoiders”, who found more than the minimum of information a threat to their overall sense of wellbeing. A broadly similar pattern is seen in cancer patients, with patients differing markedly in the quantity and type of information they want, and a small but significant number stating they do not want to be told they have an incurable or terminal illness.10

The variation in neurologists’ practice in respect of SUDEP, although out of tune with the current vogue for medicine by guidelines, reflects what every doctor knows: that patients differ vastly in their need for information. To our knowledge, there have been no studies of the impact of telling patients about SUDEP. In the whole SUDEP debate, the voice of the individual patient has been absent. Perhaps when such studies are undertaken, we will discover that Ruth Pinder’s conclusions about Parkinson’s disease patients hold true for other neurological conditions:

“knowledge of what the clinical facts mean is not always the priceless resource other writers suggest. Sometimes it is too threatening”.9

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REFERENCES

Table 5 Responses to the question “How do patients react?”

- Most take it in their stride
- Generally not surprised, take it well
- Some are alarmed, most accept possibility with equanimity
- Quite calm (surprisingly)
- Makes no difference in majority of patients
- They understand epilepsy carries a risk of death and injury, some are terrified
- Matter of fact, pragmatic
- Reassured that it does seem overall rare
- Makes no difference in the majority of patients
- They react in a positive way and welcome being told all of the facts. They view it as important information they should be aware of
- No problems, however patients are selected. I suspect I might encounter problems if I did this on a routine basis. It is important to consider psychological morbidity versus very questionable benefit in morbidity in providing information
- Terrified
- Fearfully
- Anxious
- Anxiety and resentment
- Surprised
- In my limited experience I can distinctly recall one young woman with epilepsy well controlled on monotherapy who was extremely distressed and resentful that SUDEP was discussed during her first consultation
- Fearfully – two patients never returned again!
- Young men who have never been ill, have had a first seizure, and then think they are going to die have catastrophic psychological reactions to SUDEP info. Most patients are fine about the info although it is not infrequent that they say “I really don’t want to know about that”
Focal splenial hyperintensity in epilepsy

A 13 year old boy presented with complex partial epilepsy of 10 years duration with a seizure frequency of 1–2 per month and one recent episode of secondary generalisation. Clinical and video EEG localisation was towards the right parieto-temporo-occipital region. Brain MRI scan done 5 years previously was reported as normal. He was on treatment with carbamazepine with no clinical evidence for drug toxicity. MR imaging showed a focal hyperintensity of the splenium of corpus callosum on T2 weighted sequences with evidence of cytotoxic oedema on diffusion weighted imaging (fig 2C, D). Various mechanisms have been proposed for this rare, transient MR finding in epilepsy, including drug toxicity, vasogenic oedema, and vitamin deficiency. However, cytotoxic oedema due to excitotoxicity appears to be the more likely cause as demonstrated by diffusion imaging.

References
1 Polster T, Hoppe M, Ebner A. Transient lesion in the splenium of the corpus Callosum: three further cases in epileptic patients and a pathophysiological hypothesis. J Neural Neurosurg Psychiatry 2001;70:459–63.

Figure 1. (A) T1 weighted axial SE; (B) T2 weighted axial FLAIR; (C) Coronal T2 fast SE; (D) Coronal FLAIR. Note the well defined focal hyperintensity in the splenium of corpus callosum on T2 weighted images, which is hardly visible on T1.

Figure 2. Sagittal FSE (A) and high resolution axial (B) T2 weighted images demonstrate the hyperintense signal through the centre of the splenium. On the axial diffusion weighted image the lesion appears hyperintense (C) and the corresponding ADC map shows hypointensity (D) (arrow) suggesting cytotoxic oedema as the cause of T2 hyperintensity.
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