Idiopathic generalised epilepsies: not only for the paediatrician

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Adult onset IGE is more common than generally realised

The commonest epileptic syndrome is the so-called idiopathic generalised epilepsy (IGE), which accounts for at least a third of all cases of epilepsy in the community. This proportion is even higher in the paediatric age range. The syndrome is characterised by the presence of generalised tonic clonic, myoclonic, and typical absence seizures on their own or in different combinations. The onset is usually before the age of 16. IGE has a typical electroencephalographic (EEG) pattern with paroxysms of generalised spike and wave and polyspike discharges, which is the hallmark of the syndrome. Age of onset and main seizure type are used to classify IGE further into four main sub syndromes: IGE with tonic-clonic seizures only, childhood absence epilepsy, juvenile absence epilepsy, and juvenile myoclonic epilepsy. As the majority of patients have the onset of IGE in childhood or adolescence, the international classification currently in use only recognises sub syndromes with onset in childhood. Although it is well known in epilepsy specialist centres that IGE may present in adult life, this is often not well recognised by neurologists who do not have a specialist interest in epilepsy. Therefore, the paper by Marini et al (this issue, page 192–196) is of interest as they describe 34 consecutive patients with IGE beginning after the second decade of life, including several people over the age of 50 presenting with “de novo” IGE. The authors quite rightly suggest that adult onset IGE is more common than generally realised and this is an important takeaway message. The second message is the importance of a directed diagnostic EEG strategy in all patients presenting with a first unprovoked epileptic seizure independent of age. This goes against the suggestion that after the age of 25 years, EEG is less important as an investigatory tool in epilepsy. The authors’ practice is to record an early postictal EEG, followed by a sleep deprivation EEG in negative cases and they have previously shown that this leads to a higher diagnostic yield in first seizure cases in all ages. A second spin off seems to be a relatively frequent identification of adult-onset IGE that might otherwise have been regarded as being partial epilepsy of uncertain origin. The paper also highlights the growing importance of genetics in epilepsy, particularly in IGE. Early onset IGE has a genetic aetiology with complex inheritance. Family and twin studies suggest a common genetic origin for all subtypes of IGE and this seems also to apply to the late onset form. Currently, intensive work is ongoing to clarify fully the genetic blueprints of IGE, and the Melbourne group, which authored this article, are major players in this area. For the general neurologist the recognition of adult-onset IGE has implications for accurate diagnosis and treatment. Adults with a family history of IGE and in whom other causes have been ruled out are prime candidates for adult-onset IGE. The diagnosis of adult-onset IGE can avoid unnecessary investigations, direct appropriate treatment, and allow an optimistic prognosis, and this should not be forgotten.

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magnetic field measures correlate significantly with the relative volume of lateral and mesial temporal regions. Consistent with the long latency of cognitive evoked potentials, the MEG features of interest occurred more than 400 ms after stimulus onset. After a Bonferroni correction, the only correlation coefficient considered significant was that between left temporal lobe activity and the relative volume of the left hippocampus. The smaller the number of late MEG activity sources in the left temporal region, the greater the atrophy in the mesial portion of the left temporal lobe. Definable changes in MEG may correspond to the exquisite anatomic resolution of MRI.

Different types of algorithms, embodying different assumptions, have been employed to solve for the four-dimensional origin of electrical activity within the brain. The commonest algorithm models magnetic flux as the product of single equivalent current dipoles. Despite its simplicity, this approach has given good results when compared with invasive recordings. A straightforward MEG technique is to plow mathematically through a second or so of evoked potentials, solving for dipoles every 4 ms and identifying those that show high goodness of fit and a restricted intra-cranial volume. Analysis of a single evoked potential can produce hundreds of dipoles scattered across multiple brain regions. This approach provides interesting results, and the assumptions behind it seem reasonable: but it's fair to ask whether all those dipoles represent something "real", or are merely artifacts of elaborate computer processing.

The report of Maestú and colleagues suggests that the plethora of dipoles is a valid reflection of brain activity. Significantly fewer of them are found in the atrophic left temporal lobes of Alzheimer's disease patients compared to elderly subjects. Although we still don't know what the individual dipoles mean, we have increasing reason to believe that they do reflect neuronal processing. We can hope that a greater understanding of the link between MEG dipoles and cortical activity will lead to increased applications for the unique capabilities of MEG.

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reasons for these findings is important so the design of future trials can be improved.

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NEUROLOGICAL PICTURE

Vasospastic amaurosis fugax

A 54 year old man was admitted because of repeating (10–12/day) visual disturbances in the left eye. He reported shrinkage of the visual fields and a shadow-like visual impairment progressing to complete darkness within about 3 min and lasting about 10 min, followed by complete recovery. There was no personal history of hypertension, diabetes, and smoking. General medical examination was normal. The blood pressure was 130/80 mm Hg. Investigations of standard haematological and biochemical parameters revealed elevated low density lipoprotein cholesterol 4.45 mmol/L (normal < 3.5 mmol/L) and elevated triglycerid level 2.67 mmol/L (normal range 0.45–1.80 mmol/L). Ultrasound studies of the extracranial vessel showed normal intima-media thickness (0.9 mm) and no plaque formation in the carotid bulb. Complete cardiological examination, including electrocardiography, transthoracic echocardiography, and chest x rays, were unremarkable. Magnetic resonance imaging of the brain was unremarkable, as was conventional angiography.

During examination of the retinal circulation by laser Doppler by scanning laser Doppler flowmetry1 elaborating a map of perfused retinal vessels and capillaries, the patient suffered a visual disturbance as described above. The retinal perfusion map (fig 1A) revealed impaired perfusion of the retinal temporal artery at the 11 and 12 o’clock positions (arrows), which resolved within 21 min (fig 1B). A treatment with statin to lower lipids and the antiplatelet agent copidogrel was initiated, but without influence on the events. Suspecting vasospastic amaurosis fugax,2–4 we supplemented the therapy by calcium-channel blocker cyclandelate (1200 mg daily),2 which yielded significant improvement of the clinical condition.

References

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