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

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

Results: Of the valid 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.

METHODS
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. The questionnaire also asked respondents to record patient reactions to the information. This qualitative data were assigned into three “reaction” groups under “positive”, “equanimity”, and “negative”.

RESULTS
Quantitative data
In total, 738 questionnaires were posted, of which 387 were returned. Of these, 288 were completed by consultant neurologists. As there are approximately 350 consultants in the UK, this represents 82% of the consultant body and 74% of all respondents. In addition, 63 specialist registrars (SpRs) responded, approximately 19% of trainees. The remainder comprised associate specialists, consultants in other specialties who run epilepsy clinics, and specialist nurses. Those who had attained consultant status (that is, were in possession of Central Consultants and Specialists Committee membership or equivalent) were included in the consultant neurologist group for analysis, making a total of 301. The rest, including associate specialists, were added to the SpR group, making a total of 82. The four responses from nurse specialists were excluded. Of the respondents, 120 (31%) stated a special interest in epilepsy.

Only 18 (4.7%) of respondents discussed SUDEP with all of their patients (table 1). The χ² analyses of the data are shown in table 2. Half the respondents discussed SUDEP in only one different patient circumstances (table 3).

*Number who did not reply to question.

Year of qualification (date of MB, ChB or equivalent), had no effect on whether the neurologist discussed SUDEP or not, and there was no difference in responses between registrars and consultants (table 1). Knowing about SUDEP was not thought by 47% of respondents to have any effect on patients’ quality of life. A third of respondents thought information about SUDEP caused anxiety. Most respondents (80%)...
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)

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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Our study suggests that the majority of neurologists in the UK are not following the NICE guidelines. It does not necessarily mean that patients are ignorant of SUDEP. There are many sources of information now available, notably 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, and undermines the physician’s ability to treat patients as individuals. One in depth examination of the information needs of patients with Parkinson’s disease 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.

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.”

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REFERENCES
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. 

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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.