

First Seizure

This guideline is not for seizures related to known epilepsy or pre-ecalmipsia.
If status-epilepticus follow ALS guidelines

- Features suggestive of epileptic seizures :**
- A bitten tongue (lateral tongue biting more predictive)
 - Head turning to one side during event
 - No memory of abnormal behaviour that was witnessed before, during or after the episode by someone else
 - Unusual posturing
 - Prolonged limb jerking
 - Confusion or drowsiness after the event (post-ictal)
 - Prodromal déjà vu or jamais vu

- Features NOT suggestive of epileptic seizures :**
- Prodromal symptoms that on other occasions have been abolished by sitting or lying down
 - Sweating before the episode
 - Prolonged standing that appeared to precipitate the event
 - Pallor during the episode
 - Other symptoms known to trigger vasovagal syncope (eg pain, fear, hunger).

- Assessment**
- Document a detailed description of the event (telephone witness if required)
 - Record vital signs including postural BP and temperature
 - Full neurological examination
 - Look for signs of injury
 - Look for possible underlying causes, including electrolyte disturbance, hypoglycaemia, head injury, alcohol withdrawal, CVA

- Investigations**
- ECG, Urine HCG if childbearing age
 - FBC, VBG (to include Na, Ca and glucose)

- Is a CT head required in ED – are any of the following present?**
- Age > 60 years
 - Recurrent seizure (i.e. post initial assessment of 'first' seizure)
 - Fever or immunocompromised / HIV (even without fever)
 - Recent new neurological symptoms
 - Persistent focal neurological signs
 - Post trauma
 - Confusion > 1 hour (prolonged post-ictal phase)
 - Signs of raised intra-cranial pressure (headache, vomiting, papilloedema, bradycardia, hypertension)
 - Known / suspected space occupying lesion, malignancy, anticoagulation, alcoholism, TB

No

Is patient fully recovered?
Return to baseline, alert, mobilising

- Yes**
- Discharge**
- Complete discharge letter and give patient a copy and attach a copy of their **12 lead ECG**
 - Do not routinely start anti-epileptic medication
 - Advise patient not to drive until seen in clinic and to inform [DVLA](#) of 'suspected first seizure'. Document this in the notes
 - Give all patients a copy of the First Seizure advice leaflet
 - Follow up in **First Seizure Clinic** as below if in area (postcodes – any E, IG or EC, N1, N15, N16, SE1, SE8, SE10, SE16). If not, refer own GP
 - Advise the patient to contact the Epilepsy Nurse specialists if they have not been contacted within 1 week of discharge on **0203 594 0701**
 - Refer via CRS message centre to Dr Andrew Kelso with electronic referral form on RLH How2 guide (copy into CRS)

Yes

Is CT normal?
NB patients may be admitted to CDU to await CT if stable

- No**
- CDU**
- Admit to CDU for a period of observation to allow for full recovery and / or completion of CT and / or poor social support (eg overnight)
- Exclusions:**
- GCS 12 or below
 - Recurrent seizures
 - New focal neurology
 - Fever > 38°C
 - Significant head injury or major trauma
 - Intoxication with drugs or alcohol
 - Pregnancy
 - HIV +ve
 - Underlying cause requiring in-patient treatment

- No**
- Admit**
- If any of the following:
CT abnormal
or
Exclusion to CDU (even if normal CT)
- Refer to appropriate team:
- Neurosurgery via switchboard if abnormal CT
 - Medical SpR on **45645 / bleep 1112**
- If seizures are thought to be alcohol related give Pabrinex IV (reduces the risk of status) and ensure withdrawal prophylaxis is prescribed – see Alcohol Withdrawal guidelines.

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Reference Documents

The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care NICE CG 137, January 2012

Transient Loss of Consciousness, NICE CG 109, August 2010

Guideline for the management of first seizure in the Emergency Department, CEM, December 2009