



## American Epilepsy Society

### Practice Tool: FAQ

#### Frequently asked questions (FAQs)\* about the Epilepsy Monitoring Unit (EMU)

Epilepsy centers are groups of health care professionals, usually led by a neurologist specializing in epilepsy, that focus on the care of people with seizures and epilepsy. Depending on resources, some centers focus on diagnostic and medical approaches to care of epilepsy, while comprehensive centers should be capable of offering the full range of diagnostic and treatment services, including surgical approaches and often research treatment options. The multidisciplinary team generally includes neurology, psychiatry, neurosurgery, neuroradiology, neuropsychology, nursing, social work, EEG technology, and access to other specialists such as pharmacology, and pathology. The team is skilled in the assessment and management of patients with epilepsy, including: medical, surgical, dietary therapies; clinical research; and educational, self-management and psychosocial supports for patients and families. Epilepsy centers are expected to have a good relationship with referring neurologists, primary care physicians and psychiatrists providing co-management with the patient's usual health care team and other specialists as indicated. The inpatient unit of an Epilepsy Center, called an Epilepsy Monitoring Unit (EMU), should have the capability of providing long-term video EEG telemetry to assist in diagnosis and management of people with difficult to diagnose or control seizures. Below are some **frequently asked questions (FAQs)** that patients and referring clinicians might have about epilepsy monitoring.

#### 1. When should people with seizures be referred to a specialized epilepsy center?

- When seizures are difficult to diagnose, and there is a need to confirm if a person has epilepsy or non-epileptic events (physiologic or psychogenic)
- When seizure type or epilepsy syndrome is uncertain and/or seizures are not responding to treatment
- When etiology of seizures is unknown/unclear
- When seizures persist after trials with two appropriate AEDs titrated to correct doses or the person has unacceptable medication side effects
- When comorbidities are difficult to diagnose or manage, for example behavioral difficulties, mood disorders, and/or cognitive disorders
- When surgery, stimulation devices (i.e., vagus nerve stimulation), or dietary therapy is being considered
- Children or adults with neurocutaneous disorders and epileptic encephalopathies
- Women with epilepsy who are pregnant or planning pregnancy
- Women with hormonal considerations affecting management of seizures, for example catamenial epilepsy, reproductive endocrine disorders, interactions with contraceptive treatment, menopause
- Older adults with new onset events that are not of certain etiology and may be new-onset seizures or chronic epilepsy
- People with epilepsy and their families who desire education and support for self-management or psychosocial concerns

**2. Is there anything I should do before referral for pre-surgical evaluation?** It is important that the patient and/or family fully understands the reason for referral. Epilepsy surgery is considered when seizures do not fully respond to medications and when seizures start in one part of the brain that can be safely removed. In general, children and adults with epilepsy who have not responded well to 2 or 3 trials of medication should at least be considered for epilepsy surgery. Available treatment options, including surgery, may be discussed during the initial evaluation to the epilepsy center; often this is done in the outpatient setting.

- Referral does not mean that the patient will definitely be a good candidate to have surgery. These expectations for the referral are important to address early.
- Initial evaluation includes a detailed history, prior medical, surgical and medication history, neurological exam, and reviewing any imaging (MRI brain) or prior EEGs (including ambulatory).
- If indicated, the specialist will try to capture several seizures on EEG in their EMU so that medications may be withdrawn or changed. In addition, the epilepsy team evaluation, a significant component necessary for surgery, occurs in the EMU.
- Patients are requested to bring their current medications, copies of their prior medical records and CDs or DVDs of prior neuroimaging (i.e., CT, MRI, PET, SPECT) and EEG recordings for primary review at the epilepsy center.

### **3. Why must this video EEG monitoring be accomplished in the hospital?**

There are many situations in which children and adults with epilepsy (or suspected to have epilepsy) can be adequately treated with seizure medications using history and a routine EEG to guide the physician. Additionally, outpatient EEG telemetry may be indicated to capture events that occur frequently enough to be recorded without changes to the patient's seizure medication. However, patients who may have non-epileptic events, poorly characterized or localized seizures will require provocation of seizures, usually accomplished by lowering or withdrawing anti-epileptic drugs (AEDs). In these situations, patients must be hospitalized to maintain safety.

- A continuous video EEG with video and audio recording enables review of the events from start to finish both clinically and electrographically. This can be helpful when the patient lives alone or is unaware of the semiology.
- Correlation of the observed behavioral/clinical change with the EEG clarifies if events are of central nervous system (CNS) physiological origin or may be non-epileptic. Also, real time assessment by staff and obtaining serum markers at the time of event permit this definition as well.
- Having video and synchronized EEG often allows localization of the seizure.
- Nurses or technologists can interact with the patient to determine level of consciousness and maximize patient safety
- Inpatient video EEG allows for rapid AED adjustment that would not be possible or safe otherwise.
- Video recordings can be used to help educate patients, family members, or other caregivers what the seizures look like, how to respond, and how they can use this information to help others respond appropriately to the seizures. If events are non-epileptic, recommendations for treatment may be started in the EMU and transitioned to the outpatient setting.

- Inpatient telemetry insures a more rapid solution for the common technical issues that arise from loose electrodes.
- Inpatient monitoring allows rapid assessment of overall seizure burden, including subclinical seizures, help with appropriate seizure classification/ epilepsy syndrome and management. Sleep disruption, a major provocation for seizures, can also be assessed.

#### **4. Should medications be tapered prior to admission to the EMU in order to expedite the monitoring results?**

- Medications are generally not tapered prior to admission to the EMU except under certain circumstances. Seizures resulting from AED withdrawal may be more frequent and more severe than anticipated; patients who have had complex partial seizures or absences may experience generalized tonic clonic seizures or even status epilepticus as a result of a precipitous taper prior to admission.

**5. What happens to my patient after the epilepsy monitoring is complete?** Epilepsy centers vary in their practices. It is important to find out how the center communicates with their referring providers. Letting the center know your expectations is very helpful for an ongoing productive relationship. TO FIND A National Association of Epilepsy Center (NAEC) near you [Link to NAEC](#)

\* **Practice Tools (Fact Sheets and Frequently Asked Questions)** are less restrictive than a checklist, with no perception that something has to be done. These are at the bottom of the hierarchy with regard to rigorous process. “Things to Consider” is one example of a practice tool. Information listed is to help you do your job, not tell you what to do. They could be created with an accompanying reminder list of what the practitioner should think about in the particular clinical scenario. Should not be interpreted as the ‘standard of care’, and they should probably have a disclaimer\*\*.

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