Fits & Faints:

Syncope vs Seizure

Symptom scoring helps discriminate:

**Symptom Scoring is 94% Accurate**

<table>
<thead>
<tr>
<th>Symptom Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wake with tongue cutting?</td>
<td>2</td>
</tr>
<tr>
<td>Déjà vu or jamais vu?</td>
<td>1</td>
</tr>
<tr>
<td>Emotional stress associated with loss of consciousness?</td>
<td>1</td>
</tr>
<tr>
<td>Head turning during a spell</td>
<td>1</td>
</tr>
<tr>
<td>Unresponsive, unusual posture, limb movement, or amnesia of spells? (any one of these)</td>
<td>1</td>
</tr>
<tr>
<td>Confusion after a spell</td>
<td>1</td>
</tr>
<tr>
<td>Lightheaded spells</td>
<td>-2</td>
</tr>
<tr>
<td>Sweating before spell</td>
<td>-2</td>
</tr>
<tr>
<td>Spell associated with prolonged sitting or standing</td>
<td>-2</td>
</tr>
</tbody>
</table>

If point score is $\geq 1$ the likelihood is seizure or if $< 1$ the likelihood is syncope.

Sheldon et al J Am Col Cardiol 2002
Fits & Faints:

Dr Paul Timmings
Neurologist
Hamilton

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze  
1 = slight chance of dozing  
2 = moderate chance of dozing  
3 = high chance of dozing

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING (0–3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching television</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g., a theater or meeting)</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

**SCORE RESULTS:**

1-6 Congratulations, you are getting enough sleep!  
7-8 Your score is average  
9 and up Very sleepy and should seek medical advice
Fits & Faints:

EEG

A normal EEG cannot exclude Seizure/Epilepsy (due to high false negative rate)

A test of function vs a view of structure

Useful in assessment of altered mental status

syncope /LOC ?cause

Epilepsy management

Non-convulsive status epilepticus (NCSE)

Metabolic & encephalopathic disease

Drug effects also often reflected in EEG

A normal EEG (in a patient who had a seizure) connotes 20-30% probability of second seizure by 2 yrs

An abnormal EEG that demonstrates interictal epileptogenic activity connotes a 60-75% probability of a second seizure by 2 yrs

Who Needs an EEG?

- LOC ? Cause with suspicion of seizure
- Single Seizure patients (prognostic data)
- To help define the Epilepsy Syndrome (gives prognostic information and helps select optimal therapy)
- Patients with poor or worsening Epilepsy control, - re ? new changes in EEG
- Well controlled Epilepsy patient who are wanting to consider stopping treatment.
- Altered mental status ?cause ?NCSE, including atypical dementias and some psychoses (re ?NCSE)
- Investigation of toxic / metabolic encephalopathies
- Some coma patients
- Some cerebral infections (eg Herpes, CJD, SSPE)
**EPILEPSY in OLDER PEOPLE: KEY POINTS**

Elderly have the highest incidence of seizures of any age group.

Nearly half of acute symptomatic seizures in the elderly and 30% to 50% of all epilepsy cases in this age group are associated with stroke.

In elderly, new onset of epilepsy is often associated with vague complaints such as confusion, altered mental status, or memory problems.

The differential diagnosis of seizures in the elderly should rule out spells due to other causes, such as syncope (cardiac disease), transient ischemic attack, transient global amnesia, or episodic vertigo.

In treating epilepsy, the choice of antiepileptic drug (AED) is usually dictated by seizure type and tolerability but will be complicated by co-morbidities or age-associated differences in AED pharmacokinetics.

Older and newer AEDs are both effective.

Newer AEDs generally have better overall tolerability, fewer drug interactions, more predictable kinetics, and a broader spectrum of activity; but they also have slower titration schedules and cost considerably more than older AEDs.