

**American College of Radiology
ACR Appropriateness Criteria®**

Clinical Condition: Epilepsy

Variant 1: Chronic epilepsy, poor therapeutic response. Surgery candidate.

Radiologic Procedure	Rating	Comments	RRL*
MRI head without contrast	8		O
MRI head without and with contrast	8		O
FDG-PET head	7	May be helpful in pre-op planning.	☼☼☼☼
CT head without and with contrast	6		☼☼☼
MRI functional (fMRI) head	5	May be helpful in pre-op planning.	O
Tc-99m HMPAO SPECT head	5	May be helpful in pre-op planning.	☼☼☼☼
MEG/MSI	5	Data probably equivalent to BOLD and SPECT.	O
CT head without contrast	5		☼☼☼
MRA head	3		O
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation Level

Variant 2: New onset seizure. ETOH, and/or drug related.

Radiologic Procedure	Rating	Comments	RRL*
MRI head without and with contrast	8	In the acute or emergency setting, CT may be the imaging study of choice.	O
MRI head without contrast	7	In the acute or emergency setting, CT may be the imaging study of choice.	O
CT head without and with contrast	6	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
CT head without contrast	5	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
MRA head	2		O
MRI functional (fMRI) head	2		O
Tc-99m HMPAO SPECT head	2		☼☼☼☼
FDG-PET head	2		☼☼☼☼
MEG/MSI	2		O
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation Level

Clinical Condition: Epilepsy

Variant 3: New onset seizure. Aged 18-40 years.

Radiologic Procedure	Rating	Comments	RRL*
MRI head without contrast	8	In the acute or emergency setting, CT may be the imaging study of choice.	O
MRI head without and with contrast	7	In the acute or emergency setting, CT may be the imaging study of choice.	O
CT head without and with contrast	6	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
CT head without contrast	5	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
Tc-99m HMPAO SPECT head	4		☼☼☼☼
FDG-PET head	4		☼☼☼☼
MRA head	2		O
MRI functional (fMRI) head	2		O
MEG/MSI	2		O
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation Level

Variant 4: New onset seizure. Older than age 40.

Radiologic Procedure	Rating	Comments	RRL*
MRI head without and with contrast	8	In the acute or emergency setting, CT may be the imaging study of choice.	O
MRI head without contrast	7	In the acute or emergency setting, CT may be the imaging study of choice.	O
CT head without contrast	5	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
Tc-99m HMPAO SPECT head	4		☼☼☼☼
FDG-PET head	4		☼☼☼☼
CT head without and with contrast	3	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
MRA head	2		O
MRI functional (fMRI) head	2		O
MEG/MSI	2		O
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation Level

Clinical Condition:**Epilepsy****Variant 5:****New onset seizure. Focal neurological deficit.**

Radiologic Procedure	Rating	Comments	<u>RRL*</u>
MRI head without contrast	8	In the acute or emergency setting, CT may be the imaging study of choice.	O
MRI head without and with contrast	8	In the acute or emergency setting, CT may be the imaging study of choice.	O
CT head without and with contrast	7	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
CT head without contrast	6	In the acute or emergency setting, CT may be the imaging study of choice.	☼☼☼
Tc-99m HMPAO SPECT head	3		☼☼☼☼
FDG-PET head	3		☼☼☼☼
MRA head	2		O
MRI functional (fMRI) head	2		O
MEG/MSI	2		O
<u>Rating Scale:</u> 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation Level

Expert Panel on Neurologic Imaging: John P. Karis, MD¹; David J. Seidenwurm, MD²; Patricia C. Davis, MD³; James A. Brunberg, MD⁴; Robert L. DeLaPaz, MD⁵; Pr. Didier Dormont⁶; David B. Hackney, MD⁷; John E. Jordan, MD⁸; Suresh Kumar Mukherji, MD⁹; Patrick A. Turski, MD¹⁰; Franz J. Wippold II, MD¹¹; Robert D. Zimmerman, MD¹²; Michael W. McDermott, MD¹³; Michael A. Sloan, MD, MS.¹⁴

Summary of Literature Review

Epilepsy is a common disorder, affecting approximately 0.5% to 1.0% of the United States population at any time with an incidence of 30.9 to 56.8 per 100,000 [1]. It has been estimated that about 7%-8% of the population experiences at least one epileptic seizure during their lifetimes [2]. The basic mechanism of epileptic seizures has not been fully elucidated.

The classification of epileptic seizures by the International League Against Epilepsy was last revised in 1989 (Appendix 1) [3]. The classification is important because etiologic diagnosis, appropriate treatment, and accurate prognostication all depend on the correct identification of seizures and epilepsy. There are two main seizure types: partial seizures and primary generalized seizures. Partial (formerly referred to as focal) seizures show either clinical or EEG evidence of onset from a localized area within the cerebral hemisphere. The nature of the signs and symptoms in most cases indicate the region of the brain involved by the epileptic process. Partial seizures are designated as simple or complex. Complex partial seizures are associated with loss of consciousness. In simple seizures, the epileptic process is usually confined to neocortical structures, and the limbic system and brainstem are spared. Most simple seizures are less disabling than those associated with loss of consciousness. Partial seizures can spread and develop into secondarily generalized seizures. Primary generalized seizures originate simultaneously from both cerebral

hemispheres, and clinical manifestations involve both sides of the body. Primary generalized seizures first occur at an earlier age, and are more likely to be associated with a family history of seizure disorders, but are less likely to be associated with focal cerebral lesions. Some seizures remain unclassified because the underlying mechanism of their origin or propagation is unknown [2].

Certain types of seizure disorders are likely to be associated with structural brain lesions, including tumors, infection, infarction, traumatic brain injury, vascular malformations, developmental abnormalities, and seizure-associated brain pathology (Appendix 2) [4], whereas others are not. Hence, knowledge of seizure types helps to determine whether neuroimaging is clinically indicated and what type of study is appropriate.

While the imaging evaluation of epilepsy was greatly advanced by the clinical introduction of computed tomography (CT) in the early 1970s [5,6] because of its superior soft tissue contrast, multiplanar imaging capability, and lack of beam hardening artifacts, virtually all the substrates of epilepsy are visualized with greater sensitivity and accuracy by magnetic resonance imaging (MRI) [7-15]. As a result, MRI has become the modality of choice for high-resolution structural imaging in epilepsy. Although routine evaluation techniques of all clinically available scanner field strengths may be sufficient for determining mass lesions, optimized protocols for scans obtained on high-field (>1.5 T) scanners may be necessary for evaluating partial complex epilepsy, requiring scrutiny of the hippocampus and temporal lobe for atrophy and subtle signal alteration, as well as for detecting certain structural abnormalities such as cortical dysplasias, hamartomas, and other developmental abnormalities [8,9,16-21]. Anatomic imaging identifies focal abnormality in up to 51% of patients with partial epilepsy [22]. With the widespread clinical availability of high-performance MRI systems, a comprehensive MRI examination, with functional techniques providing additional information, adding corroborative information, and improving overall accuracy, may in the future be of even greater value in epilepsy.

Although the data provided by MRI are essential in the presurgical evaluation of patients with medically refractory epilepsy, structurally detectable abnormalities are absent in many patients. In these patients, functional studies provide useful information on the location of the seizure focus. Functional imaging techniques, including positron emission tomography (PET), single-photon emission computed tomography (SPECT), magnetic source imaging (MSI), and functional MRI (fMRI), have contributed to the presurgical evaluation of patients with epilepsy [18-20,23-41].

Clinical PET with fluorodeoxyglucose (FDG) provides a measure of glucose uptake and thus metabolism. A seizure focus will typically manifest as a focus of

¹Principal Author, SW Neuro-Imaging, Phoenix, Arizona.

²Panel Chair, Radiological Associates of Sacramento, Sacramento, California.

³Vice-Chair, Northwest Radiology Consultants, Atlanta, Georgia.

⁴University of California-Davis Medical Center, Sacramento, California.

⁵Columbia University Medical Center, New York, New York.

⁶Hôpital de la Salpêtrière, Assistance-Publique-Hôpitaux de Paris, France.

⁷Beth Israel Medical Center, Boston, Massachusetts.

⁸Advanced Imaging of South Bay, Inc., Torrance, California.

⁹University of Michigan Health System, Ann Arbor, Michigan.

¹⁰University of Wisconsin, Madison, Wisconsin.

¹¹Mallinckrodt Institute of Radiology, Saint Louis, Missouri.

¹²New York Hospital-Cornell University Medical Center, New York, New York.

¹³University of California San Francisco, San Francisco, California, American Association of Neurological Surgeons.

¹⁴Carolinas Medical Center, Charlotte, North Carolina, American Academy of Neurology.

The American College of Radiology seeks and encourages collaboration with other organizations on the development of the ACR Appropriateness Criteria through society representation on expert panels. Participation by representatives from collaborating societies on the expert panel does not necessarily imply society endorsement of the final document.

Reprint requests to: Department of Quality & Safety, American College of Radiology, 1891 Preston White Drive, Reston, VA 20191-4397.

hypometabolism on interictal (between episodes of seizure activity) examinations and will be seen as a focus of increased metabolism on ictal (during seizure) examinations. Interictal FDG-PET is sensitive (84%) and specific (86%) by electroencephalogram (EEG) criteria to temporal lobe epilepsy (TLE) and 33% sensitive and 95% specific to extratemporal epilepsy. By comparison, structural imaging using a variety of MR field strengths and techniques yielded a sensitivity and specificity of 55% and 78%. SPECT utilizing perfusion agents such as 99mTc-HMPAO or 99mTc-Neurolite, as well as bolus MRI perfusion provide an assessment of regional cerebral blood flow rather than brain metabolism. A seizure focus will typically manifest as a focus of hypoperfusion on interictal examinations and will be seen as a focus of increased activity on ictal examinations. The utility of isolated interictal cerebral perfusion assessment in patients without anatomic imaging abnormality is limited [42,43]. The use of ictal/interictal subtraction imaging with coregistration on MRI and image-guided surgery datasets is proving to be more useful than interictal perfusion imaging alone [43]. Injection of the blood flow agent within 90 seconds of seizure onset does, however, appear to be required to demonstrate the expected localized increase in cerebral perfusion [44]. The use of perfusion techniques in epilepsy is therefore limited because of the technological challenge of injecting EEG-monitored patients within 90 seconds of seizure onset.

fMRI techniques include phosphorus and proton spectroscopy (MRS), perfusion, and blood oxygen level dependent (BOLD) activation. The widespread application of most of these techniques in clinical practice depends on the widespread availability of high-performance MR imagers capable of performing fast echo-planar pulse sequences (EPIs), as well as substantial data postprocessing capabilities.

MRS is a set of noninvasive techniques for in vivo chemical analysis of the brain, some of which can be performed on standard-performance clinical MR units. Although MRS has been used extensively for the past 30 years in molecular physics and chemistry, its application to the study of epilepsy is relatively recent. Widely available proton and phosphorus single-voxel techniques have consistently demonstrated metabolite changes in the epileptogenic region of the brain. MRS or chemical shift imaging (CSI) allows simultaneous acquisition of spectra from all brain regions. The pictorial display of MRS information facilitates comparison of the epileptogenic zone with the remainder of the brain and provides localizing information. CSI is not yet widely available in clinical practice. Initial studies suggest that both proton and phosphorus MRS may be useful adjunctive presurgical tests for localizing seizure foci in patients with partial epilepsy, particularly in difficult cases, potentially reducing the need for intracranial-depth electrode EEG recordings and those with extratemporal seizure foci [19,25,26,32,33,35].

Only magnetoencephalography (MEG) and EEG are capable of measuring epileptic brain activity directly and

with high temporal resolution. The temporal resolution of PET, SPECT, and fMRI is poor by comparison (sec-min). Recent improvements in MEG technology now allow whole brain coverage and overlay of source information on MR or CT images (MSI). Available data indicate that interictal MEG can be an effective tool for localization of seizure foci, in patients with medical refractory partial epilepsy. Significant shortcomings include limited availability, high cost, and assessment limited to relatively superficial and tangential sources. Nonetheless, MSI does provide unique, accurate, and useful information about epileptogenic regions in the brain, and where available, has a potential role in the diagnostic workup of most patients with epilepsy [27,29,37,40].

Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Patients in the pediatric age group are at inherently higher risk from exposure, both because of organ sensitivity and longer life expectancy (relevant to the long latency that appears to accompany radiation exposure). For these reasons, the RRL dose estimate ranges for pediatric examinations are lower as compared to those specified for adults (see Table below). Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document.

Relative Radiation Level Designations		
Relative Radiation Level*	Adult Effective Dose Estimate Range	Pediatric Effective Dose Estimate Range
O	0 mSv	0 mSv
⊕	<0.1 mSv	<0.03 mSv
⊕⊕	0.1-1 mSv	0.03-0.3 mSv
⊕⊕⊕	1-10 mSv	0.3-3 mSv
⊕⊕⊕⊕	10-30 mSv	3-10 mSv
⊕⊕⊕⊕⊕	30-100 mSv	10-30 mSv
*RRL assignments for some of the examinations cannot be made, because the actual patient doses in these procedures vary as a function of a number of factors (eg, region of the body exposed to ionizing radiation, the imaging guidance that is used). The RRLs for these examinations are designated as NS (not specified).		

Supporting Document(s)

- [ACR Appropriateness Criteria® Overview](#)
- [Procedure Contrast Information](#)
- Evidence table under review

References

1. Hauser WA, Hesdorffer DC. Epilepsy: frequency, causes and consequences. In: Hauser WA, Hesdorffer DC, eds. New York: Demos; 1990:1-51.
2. So EL. Classifications and epidemiologic considerations of epileptic seizures and epilepsy. *Neuroimaging Clin N Am* 1995; 5(4):513-526.
3. Proposal for revised classification of epilepsies and epileptic syndromes. Commission on Classification and Terminology of the International League Against Epilepsy. *Epilepsia* 1989; 30(4):389-399.
4. Kim JH. Pathology of seizure disorders. *Neuroimaging Clin N Am* 1995; 5(4):527-545.
5. Bogdanoff BM, Stafford CR, Green L, Gonzalez CF. Computerized transaxial tomography in the evaluation of patients with focal epilepsy. *Neurology* 1975; 25(11):1013-1017.
6. Gastaut H, Gastaut JL. Computerized transverse axial tomography in epilepsy. *Epilepsia* 1976; 17(3):325-336.
7. Bergen D, Bleck T, Ramsey R, et al. Magnetic resonance imaging as a sensitive and specific predictor of neoplasms removed for intractable epilepsy. *Epilepsia* 1989; 30(3):318-321.
8. Brooks BS, King DW, el Gammal T, et al. MR imaging in patients with intractable complex partial epileptic seizures. *AJNR Am J Neuroradiol* 1990; 11(1):93-99.
9. Cascino GD, Jack CR, Jr., Hirschorn KA, Sharbrough FW. Identification of the epileptic focus: magnetic resonance imaging. *Epilepsy Res Suppl* 1992; 5:95-100.
10. Forsgren L, Fagerlund M, Zetterlund B. Electroencephalographic and neuroradiological findings in adults with newly diagnosed unprovoked seizures. *Eur Neurol* 1991; 31(2):61-67.
11. Gerard G, Shabas D, Rossi D. MRI in epilepsy. *Comput Radiol* 1987; 11(5-6):223-227.
12. Heinz ER, Heinz TR, Radtke R, et al. Efficacy of MR vs CT in epilepsy. *AJR Am J Roentgenol* 1989; 152(2):347-352.
13. Kilpatrick CJ, Tress BM, O'Donnell C, Rossiter SC, Hopper JL. Magnetic resonance imaging and late-onset epilepsy. *Epilepsia* 1991; 32(3):358-364.
14. Maxwell RE, Gates JR, McGeachie R. Magnetic resonance imaging in the assessment and surgical management of epilepsy and functional neurological disorders. *Appl Neurophysiol* 1987; 50(1-6):369-373.
15. Toh KH. Clinical applications of magnetic resonance imaging in the central nervous system. *Ann Acad Med Singapore* 1993; 22(5):785-793.
16. Cascino GD, Jack CR, Jr., Parisi JE, et al. MRI in the presurgical evaluation of patients with frontal lobe epilepsy and children with temporal lobe epilepsy: pathologic correlation and prognostic importance. *Epilepsy Res* 1992; 11(1):51-59.
17. Cross JH, Jackson GD, Neville BG, et al. Early detection of abnormalities in partial epilepsy using magnetic resonance. *Arch Dis Child* 1993; 69(1):104-109.
18. Jack CR, Jr. Magnetic resonance imaging. *Neuroimaging and anatomy. Neuroimaging Clin N Am* 1995; 5(4):597-622.
19. Jackson GD. New techniques in magnetic resonance and epilepsy. *Epilepsia* 1994; 35 Suppl 6:S2-13.
20. Spencer SS. The relative contributions of MRI, SPECT, and PET imaging in epilepsy. *Epilepsia* 1994; 35 Suppl 6:S72-89.
21. Van Paesschen W, Sisodiya S, Connelly A, et al. Quantitative hippocampal MRI and intractable temporal lobe epilepsy. *Neurology* 1995; 45(12):2233-2240.
22. Wieshmann UC. Clinical application of neuroimaging in epilepsy. *J Neurol Neurosurg Psychiatry* 2003; 74(4):466-470.
23. SPECT and PET in epilepsy. *Lancet* 1989; 1(8630):135-137.
24. Adams C, Hwang PA, Gilday DL, Armstrong DC, Becker LE, Hoffman HJ. Comparison of SPECT, EEG, CT, MRI, and pathology in partial epilepsy. *Pediatr Neurol* 1992; 8(2):97-103.
25. Breiter SN, Arroyo S, Mathews VP, Lesser RP, Bryan RN, Barker PB. Proton MR spectroscopy in patients with seizure disorders. *AJNR Am J Neuroradiol* 1994; 15(2):373-384.
26. Cendes F, Andermann F, Preul MC, Arnold DL. Lateralization of temporal lobe epilepsy based on regional metabolic abnormalities in proton magnetic resonance spectroscopic images. *Ann Neurol* 1994; 35(2):211-216.
27. Crisp D, Weinberg H, Podrouzek KW. Imaging techniques in the localization of epileptiform abnormalities. *Int J Neurosci* 1991; 60(1-2):33-57.
28. DeCarli C, McIntosh AR, Blaxton TA. Use of positron emission tomography for the evaluation of epilepsy. *Neuroimaging Clin N Am* 1995; 5(4):623-645.
29. Ebersole JS, Squires KC, Eliashiv SD, Smith JR. Applications of magnetic source imaging in evaluation of candidates for epilepsy surgery. *Neuroimaging Clin N Am* 1995; 5(2):267-288.
30. Engel J, Jr. The use of positron emission tomographic scanning in epilepsy. *Ann Neurol* 1984; 15 Suppl:S180-191.
31. Franck G, Maquet P, Sadzot B, et al. Contribution of positron emission tomography to the investigation of epilepsies of frontal lobe origin. *Adv Neurol* 1992; 57:471-485.
32. Garcia PA, Laxer KD. Magnetic resonance spectroscopy. *Neuroimaging Clin N Am* 1995; 5(4):675-682.
33. Garcia PA, Laxer KD, van der Grond J, Hugg JW, Matson GB, Weiner MW. Phosphorus magnetic resonance spectroscopic imaging in patients with frontal lobe epilepsy. *Ann Neurol* 1994; 35(2):217-221.
34. Jackson GD, Connelly A, Cross JH, Gordon I, Gadian DG. Functional magnetic resonance imaging of focal seizures. *Neurology* 1994; 44(5):850-856.
35. Kuzniecky R, Elgavish GA, Hetherington HP, Evanochko WT, Pohost GM. In vivo 31P nuclear magnetic resonance spectroscopy of human temporal lobe epilepsy. *Neurology* 1992; 42(8):1586-1590.
36. Latchaw RE, Hu X. Functional MR imaging in the evaluation of the patient with epilepsy. Functional localization. *Neuroimaging Clin N Am* 1995; 5(4):683-693.
37. Lewine JD, Orrison WW, Jr. Spike and slow wave localization by magnetoencephalography. *Neuroimaging Clin N Am* 1995; 5(4):575-596.
38. Mullan BP, O'Connor MK, Hung JC. Single photon emission computed tomography. *Neuroimaging Clin N Am* 1995; 5(4):647-673.
39. Nakasu Y, Nakasu S, Morikawa S, Uemura S, Inubushi T, Handa J. Diffusion-weighted MR in experimental sustained seizures elicited with kainic acid. *AJNR Am J Neuroradiol* 1995; 16(6):1185-1192.
40. Rowley HA, Roberts TP. Functional localization by magnetoencephalography. *Neuroimaging Clin N Am* 1995; 5(4):695-710.
41. Warach S, Levin JM, Schomer DL, Holman BL, Edelman RR. Hyperperfusion of ictal seizure focus demonstrated by MR perfusion imaging. *AJNR Am J Neuroradiol* 1994; 15(5):965-968.
42. Siegel A, Lewis P, Siegel AM. The value of interictal brain SPECT in epilepsy patients without mesial-temporal sclerosis. *Clin Nucl Med* 2002; 27(10):716-720.
43. So EL, O'Brien TJ, Brinkmann BH, Mullan BP. The EEG evaluation of single photon emission computed tomography abnormalities in epilepsy. *J Clin Neurophysiol* 2000; 17(1):10-28.
44. Avery RA, Zubal IG, Stokking R, et al. Decreased cerebral blood flow during seizures with ictal SPECT injections. *Epilepsy Res* 2000; 40(1):53-61.

The ACR Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the FDA have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

Table 1. Definitions

Seizure	A finite event of altered cerebral function because of excessive and abnormal electrical discharges in the brain cells. A clinical seizure is accompanied by signs and symptoms. When no overt signs or symptoms are present, the event is referred to as a subclinical or an electrographic seizure and can only be detected by electroencephalographic recording (EEG).
Provoked seizure	A seizure is said to be provoked when one or more acutely precipitating factors are identified. Also referred to as acute symptomatic seizures. Examples of acute brain disturbances that can provoke seizures include intracranial infections, strokes, head injuries, and medication withdrawal.
Remote unprovoked seizure	Seizure that occurs more than 1-2 weeks after the inciting factor (remote symptomatic or predisposing factor). This type of seizures carries a higher risk of recurrence than idiopathic unprovoked seizures.
Idiopathic unprovoked seizures	Seizure that occurs in the absence of acutely provoking or remotely predisposing factors.
Partial seizures	Seizure that originates from a localized area within the brain. Designated as complex partial if associated with loss of consciousness, and simple partial if not.
Generalized seizures	Seizure that originates simultaneously from both cerebral hemispheres.
Epilepsy	A chronic condition predisposing a person to recurrent epileptic seizures. The predisposition may be genetic or acquired.
Epilepsy syndrome	An epileptic disorder characterized by a cluster of signs and symptoms customarily occurring together.

Appendix 1. Outline of the International Classification of Epileptic Seizures

I. Partial Seizures (seizures with focal onset)

- i) Simple partial seizures (consciousness not impaired)
 - (1) With motor signs
 - (2) With somatosensory or special-sensory symptoms
 - (3) With autonomic symptoms or signs
 - (4) With psychic symptoms (disturbance of higher cerebral functions)
- ii) Complex partial seizures (consciousness impaired)
 - (1) Starting as simple partial seizures
 - (a) Without automatisms
 - (b) With automatisms
 - (c) With impairment of consciousness at onset without automatisms (impairment of consciousness only)
- iii) Partial seizures evolving into secondarily generalized seizures.

II. Generalized Seizures

- i) Absence seizures and atypical absence seizures (may have the following components):
 - Mild clonic, atonic, tonic, or autonomic activities, or automatic behavior
- ii) Myoclonic seizures
- iii) Clonic seizures
- iv) Tonic seizures
- v) Tonic-clonic seizures
- vi) Atonic seizures

III. Unclassified Epileptic Seizures

Appendix 2. Outline of the International Classification of Epilepsies and Epileptic Syndromes

I. Localization-Related (focal, local, partial) Epilepsies and Syndromes

- i) Idiopathic (with age-related onset)
 - (1) Benign childhood epilepsy with centrotemporal spike
 - (2) Childhood epilepsy with occipital paroxysms
 - (3) Primary reading epilepsy
- ii) Symptomatic
 - (1) Chronic progressive epilepsia partialis continua of childhood (Kojewnikow's syndrome)
 - (2) Temporal lobe epilepsies
 - (3) Frontal lobe epilepsies
 - (4) Parietal lobe epilepsies
 - (5) Occipital lobe epilepsies
- iii) Cryptogenic

II. Generalized Epilepsies and Syndromes

- i) Idiopathic (with age-related onset)
 - (1) Benign neonatal familial convulsions
 - (2) Benign neonatal convulsions
 - (3) Benign myoclonic epilepsy in infancy
 - (4) Childhood absence epilepsy (pyknolepsy)
 - (5) Juvenile absence epilepsy
 - (6) Juvenile myoclonic epilepsy (impulsive pete mal)
 - (7) Epilepsy with grand mal seizures on awakening
 - (8) Other generalized idiopathic epilepsies not defined above
 - (9) Epilepsies with seizures precipitated by specific modes of activation
- ii) Cryptogenic or symptomatic
 - (1) West syndrome (infantile spasms, Blitz-Nick-Salaam Krämpfe)
 - (2) Lennox-Gastaut syndrome
 - (3) Epilepsy with myoclonic-astatic seizures
 - (4) Epilepsy with myoclonic absences
- iii) Symptomatic
 - (1) Nonspecific etiology
 - (a) Early myoclonic encephalopathy
 - (b) Early infantile epileptic encephalopathy with suppression-burst
 - (c) Other symptomatic generalized epilepsies not defined above
 - (2) Specific syndromes
 - (a) Epileptic seizures complicating disease states

III. Epilepsies and Syndromes Undetermined Whether Focal or Generalized

- i) With both generalized and local seizures
 - (1) Neonatal seizures
 - (2) Severe myoclonic epilepsy in infancy
 - (3) Epilepsy with continuous spike-waves during slow wave sleep
 - (4) Acquired epileptic aphasia (Landau-Kleffner syndrome)
 - (5) Other undetermined epilepsies not defined above

IV. Special Syndromes

- i) Situation-related seizures
 - (1) Febrile convulsions
 - (2) Isolated seizures or isolated status epilepticus
- ii) Seizures occurring only with acute metabolic or toxic event