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Epilepsy: Beyond Seizure Impact

Announcer:
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Dr. Aaronson:
This is CME on ReachMD, and I'm Dr. Scott Aaronson. Joining me today is Dr. Raman Sankar.

Dr. Sankar, can you start by telling us the definition of drug-resistant epilepsy, or DRE, and the impact its undertreatment has on quality of life and clinical aspects?

Dr. Sankar:
Yeah. Glad to join you today again, Dr. Aaronson. And the definition of drug-resistant epilepsy has been formalized by the International League Against Epilepsy, and they now consider drug-resistant epilepsy as defined by failure of at least trials with 2 different medications used at an appropriate dose, either by themselves or in combination. The patient does not achieve seizure freedom under those circumstances, that patient is said to have drug-resistant epilepsy.

The impact of the seizures that remain are significant, and the quality of life has been the major combined measure that has been used to assess how the patient is doing. And while there are many facets to the quality of life, 2 things particularly stand out, and one of them is that a high detractor from quality of life appears to be side effects of medications. The other factor is comorbidities that come with epilepsy. And the most important comorbidity appears to be depression. The depression per se is not always treatment resistant, but obviously the seizures are, and the depression goes with it. Then there are associated factors such as impact on cognition, which can be related to the epilepsy itself, but also to the medications. Likewise, sleep.

And then a very important issue is SUDEP, which stands for sudden unexplained death in epilepsy. And this is something we discuss with the patients at the beginning of the diagnostic process as a risk factor. The major risks for SUDEP appear to be relatively young adults, and it often is exaggerated by lack of adherence or lack of compliance to therapy and in terms of seizure type, particularly with generalized tonic-clonic or convulsive seizures. So these are the ones that are the highest risk factors.

So when we come to the neuromodulatory approaches, we actually can address multiple issues here. One is that the patient is already on a couple of medications that he has failed, but we pointed out that the quality of life is affected very much by drug side effects, so neuromodulation brings a nonpharmacologic approach to treatment, and that's a big advance.

Secondly, with VNS, we definitely have good registry data showing that SUDEP rates are diminished. And so we say that the physicians do not need to wait very long to consider VNS. If somebody does not look like they are suitable candidates for straightforward surgical removal of a focus, they are probably good candidates for VNS if they have failed a couple of medications and continue to experience side effects and mood disorders.

Dr. Aaronson:

I would just like to underscore some of the comments that Dr. Sankar made about that comorbidity between difficult-to-treat depression as well as difficult-to-treat epilepsy.

Part of the reason we began investigating VNS in difficult-to-treat depression were the findings from some of the initial studies from the late 1990s on VNS in epilepsy and found that folks who were comorbid for depression had significant improvements in their depression after they got VNS. That led to us beginning to study VNS in difficult-to-treat depression, albeit much more sick depressed people than Dr. Sankar was talking about. We had the bottom line at least 4 failures of treatment in the current episode.

The other point I want to underscore is that the quality-of-life issue is important in both of these populations. Both epilepsy and depression have a marked effect on people's quality of life and enjoyment. And that's actually where we separate the best when we're looking at our data within VNS for difficult-to-treat depression.

That's our program for today. Thank you, Dr. Sankar, for joining me on this journey. And our time's up. Thanks for listening.

Dr. Sankar:
Thank you, Dr. Aaronson.

Announcer:
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