Diagnosis & Management of Neonatal Seizures
More than Meets the Eye

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Neurology Director, LPCH Neuro NICU
Disclosures

• I have no conflicts of interest
• I will discuss off-label use of anti-epileptic drugs (AEDs) for treatment of neonatal seizures
Acknowledgements

Nick Abend
Bob Clancy
Don Olson
Learning Objectives

At the conclusion of this activity, participants should be able to...

1. Recognize the unique challenges in diagnosing neonatal seizures.
2. State the most high-yield diagnostic test for identifying cause of neonatal seizures.
Overview

• Do Seizures Matter?

• Diagnosis of Neonatal Seizures

• Management of Neonatal Seizures
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• Do Seizures Matter?

• Diagnosis of Neonatal Seizures

• Management of Neonatal Seizures

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Baby Transferred for Cooling...

- Term born girl born via crash caesarean section after cord prolapse
- Apgars 1, 2, 4, 6
- Transferred to your hospital for therapeutic hypothermia
- Day 1: the resident notices some “jittery” movements that she notes might be shivering, or perhaps clonus?
- Does it really matter if these are seizures?
How could we find out if neonatal seizures are harmful or not?

- Animal Studies
- Examine the way seizures affect brain metabolism and MRI findings
- Follow babies with seizures and compare outcomes to sick babies without seizures
Subclinical seizures: effects on intracranial pressure (ICP) & brain lactate levels

In adults with traumatic brain injury, ICP and lactate/pyruvate ratio significantly higher during than between seizures.

Vespa P, Critical Care Medicine, 2007
Biomarkers of injury in neonatal seizures

- 90 babies with HIE
- 33 with seizures
- MRI d 1-13
- Dose effect with worse seizure score associated with higher lactate/choline

Miller SP et al. Neurology 2002;58:542-548
Untreated seizures are suspected to contribute to worsened outcomes.

- Among at-risk neonates, presence of seizures, greater number of seizures, and longer duration all correlate with worse outcomes
  - For every 1-min increase of total seizure burden, odds of abnormal outcome increase by 2.2%*
  - For every 1-min increase in maximum hourly seizure burden, the odds of an abnormal outcome increase by 16%.*
- Among neonates with seizures, those with status epilepticus are more likely to have later epilepsy and neurodevelopmental disability
Neonatal Seizures and IQ at 4 years

- 77 term neonates with Hypoxic Ischemic Encephalopathy.
- Analysis stratified by:
  - Seizure severity:
    - Scored 0-10 by a single reader based on seizure number, duration, time of onset, AED responsiveness, EEG background and EEG seizures.
  - Severity of HIE as seen on MRI:
    - All babies scanned in the acute period; scored using a validated method
- Full Scale IQ (FSIQ) at 4 years lower with seizures, evidence for a dose effect, even after correction for MRI

<table>
<thead>
<tr>
<th>FSIQ score, mean (95% CI)</th>
<th>Severe seizures (n = 11)</th>
<th>Mild/moderate seizures (n = 14)</th>
<th>No seizures (n = 52)</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unadjusted</td>
<td>64.7 (52.6 to 76.9)</td>
<td>83.1 (72.4 to 93.9)</td>
<td>100.2 (94.6 to 105.8)</td>
<td>&lt; .0001</td>
</tr>
<tr>
<td>Adjusted†</td>
<td>67.2 (54.6 to 79.8)</td>
<td>82.7 (72.7 to 92.7)</td>
<td>96.9 (90.7 to 103.1)</td>
<td>.001</td>
</tr>
</tbody>
</table>
Seizures Associated with Outcome in CHD

- The Boston Circulatory Arrest Study
- Continuous EEG (cEEG) recorded for 48 hours after repair of Transposition of the Great Arteries (TGA)
- EEG seizures (19%) 3x more common than clinical seizures (6%).
  - Most infants with EEG seizures had multiple seizures, beginning between 13 and 36 h postoperatively.
- EEG seizures were not read as clinical studies, but were read later as research studies
- EEG seizures appeared in 25 of 126 (20%) infants
  - were associated with an 11.2 point drop on Bayley PDI scores @ 1 year (p=0.002)

Bellinger et. al. NEJM 1995; 332:549-55
Seizures still affecting outcomes at later follow up

• At 4-year follow up:
  – Seizures in the perioperative period, detected either clinically or by cEEG, were associated with lower mean IQ scores (12.6 and 7.7 points, respectively)
  – Seizures associated with increased risk of neurological abnormalities (odds ratios, 8.4 and 5.6, respectively).

• At 16-year follow up
  – “The occurrence of seizures in the postoperative period was the medical variable most consistently related to worse outcomes.”

• Studies of outcome after CHD are now expected to include evaluation for seizures!

Bellinger et al Circulation 1999; 100:526-532
Bellinger et al Circulation 2011; 124: 1361-9
Impact of non-convulsive seizures

Acute Seizure

Systemic Dysfunction
(perfusion, oxygenation, metabolic demand)

Brain Injury

Inappropriate Medication

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Influence of etiology

Schematic

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• Do Seizures Matter?

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Problems after Surgery...

– Your patient is a 36-week boy with congenital heart disease now recovering after surgery on day 3
– He is sedated and paralyzed on a ventilator
– Throughout the day, there are paroxysmal spikes in heart rate and blood pressure without explanation.
– Are these seizures?
Suspected Seizures

- 1-5 per 1000 in term newborns
- Unclear for NICU preterms
  - Clinically: 1 in 200
  - On aEEG: Up to 48%
  - On continuous video EEG: 5%
- Diagnosis is a challenge
  - Up to 85% of neonatal seizures have no clinical signs
  - 1/3 of neonates with seizures have only subclinical seizures
  - Up to 74% of suspected clinical seizures are not epileptic seizures.
- Electroclinical “uncoupling” is common
  - 42-58% after phenytoin or phenobarbital
- Overtreatment is not benign.
  - Overuse of seizure meds prolongs length of stay
  - Prophylactic seizure medications associated with increased morbidity

1. Davis AS. J Pediatr 2010
2. Shah DK Pediatr Res 2010
5. Lloyd RO. J Pediatr 2017

Clancy, Legido & Lewis Epilepsia 1988
Mizrahi & Clancy, Epilepsia 2001
Miller, Neurology 2002
McBride, Neurology 2000
Pisani, Neurology 2007
Wyatt, Pediatrics 2007
Glass, J Pediatr 2009
Total Recorded Electrographic Seizure Activity Versus Total Duration of Observed Clinical Seizures in Nine Patients Recorded by Continuous Video-EEG During the First 72 Hours of Life

Continuous EEG (cEEG) is the Gold Standard for Diagnosis

- Traditional 60 minute EEG is limited for capturing seizures
  - Many high risk neonates have no seizures in the first hour of monitoring, but will have seizures if recording is continued for 24 hours
  - In HIE, up to 50% of seizures start after the first 24 hours
  - In cooling, ~5% will have seizures only during rewarming
- Seizure medicines cause “uncoupling”- the outward signs go away, but the seizure continues
  - Uncoupling observed in 50-60%
- Also a high risk of overdiagnosis based on clinical signs alone
  - Jitteriness, sleep myoclonus, abnormal movements, vital sign fluctuations
  - One series found 73% of “clinical seizures” documented in nursing notes had no EEG correlate

McBride et al. Nerology 2000
Wusthoff et al. J Child Neuro 2011
Scher MS et al. Pediatr Neurol 2003
Boylan GB et al. ADC Fetal Neonatal Ed 2002
Murray DM et al. ADC Fetal Neonatal Ed 2008
aEEG for Seizure Detection

- Dual channel aEEG with raw EEG can identify 40-90% of patients with seizures
- aEEG identifies 12-80% of individual seizures
  - Highly dependent on user experience
  - Dependent on availability of raw EEG for confirmation
  - Shorter seizures more likely missed
- aEEG alone may overpredict seizures 50-100%
- Artifact can interfere with interpretation
  - Significant artifact present in 12-60% of records
  - Especially if artifact outside 2-15 Hz range
- Typically, raw EEG is available, but must set options to display it

Lawrence et al. J Pediatr 2007
Frenkel et al. Clin Neurophys 2011
Lawrence R et al, J Pediatr 2009

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Impact of Monitoring

- Implementation of cEEG in a Neuro NICU\(^1\)
  - 51% → 48% with clinically diagnosed seizures
  - 34% → 53% had seizures on EEG
  - 0% → 14% with subclinical seizures diagnosed
  - 70% → 37% discharged on antiseizure medicine
  - 62.2 mg/kg → 46 mg/kg mean phenobarbital

- cEEG and aEEG Influences Management\(^2\)
  - Spot EEG only vs aEEG vs cEEG
  - Adjust risk of antiseizure med use ↓ 67%
  - With aEEG ↓ 38%

2. Jan S. Dev Neurosci 2017
Impact of Monitoring

• Monitoring with a standard treatment protocol\(^2\)
  • Phenobarbital levels 56.8 → 41 \(\mu\)g/ml
  • Status epilepticus 46 → 36%
  • Length of stay decreased 9.7 days

• Neurocritical care service with VEEG\(^2\)
  • Received 30 mg/kg less phenobarbital
  • 5 fewer days seizure medicine

1. Harris ML. J Child Neuorlogy 2016
2. Wietstock SO. J Child Neurology 2015
• Single center observational study
• Among 211 neonates, presence of status epilepticus conferred OR 8.82 for death prior to discharge
• For each day of delay from admission to cEEG, mortality OR increased by 5.5%
ACNS Guideline

The American Clinical Neurophysiology Society’s Guideline on Continuous Electroencephalography Monitoring in Neonates

Renée A. Shellhaas,* Taeun Chang,† Tammy Tsuchida, † Mark S. Scher, † James J. Riviello, † Nicholas S. Abend, † Sylvie Nguyen, † Courtney J. Wusthoff, †# and Robert R. Clancy

J Clin Neurophysiol 2011;28: 611-617
## High-Risk Conditions for Seizures

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute neonatal encephalopathy</td>
<td>HIE, postnatal collapse</td>
</tr>
<tr>
<td>Cardiac or pulmonary risk for brain injury</td>
<td>ECMO, congenital heart defects perioperatively</td>
</tr>
<tr>
<td>CNS infection</td>
<td>Meningitis, encephalitis</td>
</tr>
<tr>
<td>CNS trauma</td>
<td>Subarachnoid bleeding, nonaccidental trauma</td>
</tr>
<tr>
<td>Inborn errors of metabolism</td>
<td>Various</td>
</tr>
<tr>
<td>Stroke</td>
<td>Arterial stroke, venous thrombosis</td>
</tr>
<tr>
<td>At-risk preterm infants</td>
<td>Acute IVH</td>
</tr>
<tr>
<td>Genetic/syndromic disease</td>
<td>Cerebral dysgenesis, multiple anomalies with encephalopathy</td>
</tr>
</tbody>
</table>
Problems after Surgery…

• Your patient is a 36-week boy with congenital heart disease now recovering after surgery on day 3
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Problems after Surgery...
Overview

• Do Seizures Matter?

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A Patient is Admitted from the ER...

- Term born boy to a G1P1 28-year old mother
- Uncomplicated pregnancy; good prenatal care
- Delivery was vacuum-assisted vaginal following decelerations in the second stage
- Apgars 3, 5, 9
- Discharged home with mom day 2
- Day 4: three episodes of duskiness and funny breathing prompting parents to come to ED
- EEG confirms these are seizures
- What next?

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Most Neonatal Seizures are Symptomatic

- ~80% of neonatal seizures are symptomatic of acute brain injury
- Common causes:
  - Cerebral hypoxia-ischemia (~50% in US)
  - Stroke/hemorrhage (15-30%)
  - Infection
  - Malformations
  - Electrolytes/hypoglycemia
- ~20% due to early-onset epilepsy
  - KCNQ2 mutations most common
  - Brain malformations/other syndromes

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Evaluation for Cause of Seizures

- Acutely: head ultrasound, basic labs, EEG
- As soon as possible: MRI
  - ~90% will have diagnosis by MRI
  - acute brain injury or structural abnormality
- If MRI normal:
  - Is there a benign or malignant EEG pattern?
  - Any clinical signs to indicate a particular diagnosis?
  - Genetic testing identifies a cause in >60% when MRI is normal
A Patient is Admitted from the ER...

- Term born boy to a G1P1 28-year old mother
- Uncomplicated pregnancy; good prenatal care
- Delivery was vacuum-assisted vaginal following decelerations in the second stage
- Apgars 3, 5, 9
- Discharged home with mom day 2
- Day 4: three episodes of duskiness and funny breathing prompting parents to come to Emergency Department
- Found to have a KCNQ2 mutation
Principles of Management

• Confirm “seizures” are seizures.
• Look for a cause as you treat
• Treat early and consistently.
  • Status Epilepticus is a neurological emergency
  • Untreated seizures may contribute to worsened outcomes.
  • Overtreatment is not benign.
• Be explicit about goals of treatment.
Goal of Treatment

• Complete resolution of seizures on EEG?

• Reduction of seizure burden?

• Reduction of clinical seizure burden?
## Trends in Treatment Selection

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>n=2044</td>
<td>n=2008</td>
<td>n=1688</td>
<td>n=1781</td>
<td>n=1613</td>
<td></td>
</tr>
<tr>
<td><strong>Phenobarbital</strong> (%)</td>
<td>2031 (99.4%)</td>
<td>1980 (98.6%)</td>
<td>1656 (98.1%)</td>
<td>1743 (97.9%)</td>
<td>1554 (96.3%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Phenytoin</strong> (%)</td>
<td>301 (14.7%)</td>
<td>312 (15.5%)</td>
<td>233 (13.8%)</td>
<td>207 (11.6%)</td>
<td>178 (11.0%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Levetiracetam</strong> (%)</td>
<td>28 (1.4%)</td>
<td>119 (6.0%)</td>
<td>171 (10.1%)</td>
<td>190 (10.7%)</td>
<td>230 (14.3%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Carbamazepine</strong> (%)</td>
<td>11 (0.5%)</td>
<td>11 (0.6%)</td>
<td>5 (0.3%)</td>
<td>0 (0%)</td>
<td>3 (0.2%)</td>
<td>0.0025</td>
</tr>
<tr>
<td><strong>Lidocaine</strong> (%)</td>
<td>9 (0.4%)</td>
<td>10 (0.5%)</td>
<td>9 (0.5%)</td>
<td>4 (0.2%)</td>
<td>7 (0.4%)</td>
<td>0.544</td>
</tr>
<tr>
<td><strong>Topiramate</strong> (%)</td>
<td>0 (0%)</td>
<td>2 (0.1%)</td>
<td>4 (0.2%)</td>
<td>5 (0.3%)</td>
<td>0 (0%)</td>
<td>0.3579</td>
</tr>
</tbody>
</table>

## Trends in Treatment Selection

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Phenobarbital–phenytoin</td>
<td>184 (80%)</td>
<td>168 (62%)</td>
<td>118 (47%)</td>
<td>114 (42%)</td>
<td>101 (36%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Phenobarbital–levetiracetam</td>
<td>13 (6%)</td>
<td>52 (19%)</td>
<td>85 (34%)</td>
<td>113 (42%)</td>
<td>137 (49%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>PB–PHT–LVT</td>
<td>7 (3%)</td>
<td>16 (6%)</td>
<td>18 (7%)</td>
<td>12 (4%)</td>
<td>9 (3%)</td>
<td>0.7016</td>
</tr>
<tr>
<td>PB–LVT–PHT</td>
<td>1 (0.5%)</td>
<td>10 (4%)</td>
<td>10 (4%)</td>
<td>14 (5%)</td>
<td>8 (3%)</td>
<td>0.096</td>
</tr>
<tr>
<td>Levetiracetam–phenobarbital</td>
<td>2 (1%)</td>
<td>1 (0.4%)</td>
<td>5 (2%)</td>
<td>8 (3%)</td>
<td>12 (4%)</td>
<td>0.0007</td>
</tr>
<tr>
<td>Phenobarbital–lidocaine</td>
<td>6 (3%)</td>
<td>6 (2%)</td>
<td>5 (2%)</td>
<td>2 (1%)</td>
<td>4 (1%)</td>
<td>0.1544</td>
</tr>
<tr>
<td>Phenytoin–phenobarbital</td>
<td>8 (3%)</td>
<td>8 (3%)</td>
<td>2 (1%)</td>
<td>2 (1%)</td>
<td>1 (0.4%)</td>
<td>0.0008</td>
</tr>
</tbody>
</table>

Conventional Approach

- **Phenobarbital**
  - 20 mg/kg load x1-2 (to level of 40*)
  - 4-6 mg/kg/d maintenance

- **Phenytoin**
  - 15-20 mg/kg load x1 (to level 15-20*)
  - 5-10 mg/kg/d maintenance

- **Benzodiazepine**
  - Lorazepam: 0.1mg/kg
  - Midazolam infusion

~15-20 minutes between steps
*Post-load levels 1-2 hours after

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Phenobarbital

- Overall, seizure-reduction efficacy of 43%\(^1\)
  - In combination with PHT, 60%
- Inconsistent practices re: loading vs maintenance
  - Continue through acute period
  - 23% surveyed “always” continue maintenance\(^2\)
- Pros: familiar, has some evidence basis, long half-life
- Cons: respiratory depression, sedation, long half-life

Phenytoin

- Overall, seizure-reduction efficacy of 45%\textsuperscript{1}
  - In combination with PB, 60%
- Loading vs maintenance dosing
  - Maintenance dosing difficult due to pharmacokinetics, drug interactions.
- Fosphenytoin
  - Much more expensive (20x)
  - Fewer infusion-related complications
- Pros: Na+ channel blocker, quick infusion
- Cons: hypotension, bradycardia, narrow therapeutic range

Benzodiazepines

- At some centers, preferred second-line drug. \(^1\)
- Some evidence of efficacy in seizures refractory to PB + PHT\(^2\)
- Loading vs maintenance dosing
- Midazolam
  - 15-60 microgram/kg load
  - Infusion 150 up to 300 microgram/kg/hour
  - Tighter titrations 1→18 micrograms/kg/min also used
  - Paradoxical myoclonus has been reported
- Pros: easy to titrate, commonly used agents
- Cons: sedation, still acting on GABA-R

Levetiracetam

- Case series show safety & tolerability among neonates at 10-50 mg/kg/day\(^1,2,3\)
- Retrospective series suggest efficacy
- Randomized trial currently underway
- Pros: much less sedating, renal metabolism
- Cons: limited data on efficacy, larger volume and slower infusion rate

1. Furwentsches A. Seizure 2010.

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My Approach

Phenobarbital
- 20 mg/kg load x2 (to level >40*)
- 4-6 mg/kg/d maintenance

Phenytoin (or lidocaine?)
- 20 mg/kg load x1 (to level 15-20*)
- 5-10 mg/kg/d maintenance div TID

Levetiracetam
- 40-60 mg/kg load x1-2
- 40-60 mg/kg/day maintenance div TID

~15-20 minutes between steps
*Post-load levels 1-2 hours after
Summary

• There is evidence to suggest neonatal seizures can be harmful, though more research is needed.
• Neonatal seizures cannot be reliably diagnosed by clinical observation:
  – 80-90% are subclinical.
  – cEEG monitoring is the gold standard for dx.
• Babies with brain injury are at high risk for seizures:
  – Most neonatal seizures are symptomatic of acute injury.
• Current drugs are imperfect for neonatal seizures; trials of new agents are ongoing.

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Questions?