**National Institute for Health and Clinical Excellence**

**Epilepsy (update)**

**Stakeholder Comments**

Please enter the name of your registered stakeholder organisation below.

NICE is unable to accept comments from non-registered organisation or individuals. If you wish your comments to be considered please register via the [NICE website](#) or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.

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<tr>
<th>Stakeholder Organisation:</th>
<th>Epilepsy Action</th>
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<tbody>
<tr>
<td>Name of commentator:</td>
<td>Peter Scott</td>
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**Order number** (For internal use only)

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**Comments**

Please insert each new comment in a new row.

Please do not paste other tables into this table, as your comments could get lost – type directly into this table.

Example Full 16 45 Our comments are as follows …….  

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Firstly, can we thank the Guideline Development Group (GDG) for taking on-board, and acting upon, the majority of comments submitted by Epilepsy Action in the first guideline consultation.

We welcome this second opportunity to comment, but would have appreciated longer than the two week window to consult and formulate a response. Therefore this response is based upon the information we have received and processed in this time, and may not be a comprehensive review of the guideline.

2 | General  |             |             |

In NICE’s 2009 consultation into the scope of the review of the guidelines for epilepsy, Epilepsy Action raised serious concerns about the limiting nature of the review’s proposed focus. We believe that there have been significant advances and changes in the treatment of epilepsy since the first guideline was being constructed in 2003, significant enough to merit a full guideline review. The proposed focus was carried through to the review itself, and we know has now lead to
disagreements in the epilepsy community about the merit of the guideline update, and the reputation of the guideline itself.

We hope that the next time NICE reviews these guidelines, it does so by conducting a full review and that in future, serious concerns raised at early stages are fairly investigated.

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<td>In the previous consultation, Epilepsy Action requested that the Guideline include the latest incidence figures for epilepsy based upon the latest population figures. Thank you for agreeing to update these figures. While the figures in the Full Guideline have been updated accordingly, the figures used in the NICE Guideline have not, and remain the 2004 figures. Could the GDG please update the figures in the NICE Guideline to match those now used in the Full Guideline, for accuracy and consistency.</td>
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<td>Thank you for updating the incidence figures in the Full Guideline, in-line with the latest available data. There is however one typographical error in this information. The Quality and Outcomes Framework (QOF) includes a register of all those receiving treatment by anti-epileptic drugs (AEDs) who are aged 18 and over (indicator EPILEPSY6), not aged 15 and over as is stated. The QOF does not record the number of under-18s who receive treatment by AED.</td>
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|   | In the first consultation of this guideline, we put forward a suggestion for an additional recommendation based on bone health issues (stakeholder comments response, page 97, 30.0.5). We cannot agree with the GDG that recommendation 1.9.1.1 is sufficient to warn of the risks posed to bone density by continuing treatment on certain anti-epileptic drugs. Bone health issues are a concern for many on long term AED treatment, namely enzyme-inducing AEDs carbamazepine, phenytoin, primidone, phenobarbital and the non-enzyme inducing sodium valproate (MHRA Drug Safety Update, Volume 2 Issue 9, April 2009). The MHRA drug safety update indicates to us that the associated risks of long term AED treatment, and ways to minimise these risks, are not being adequately discussed with patients. We believe this clinical guidance should include indicators for appropriateness to prescribe vitamins or order further investigations (such as a
DEXA scan). It should also include a warning of the cardiotoxic effects of AEDs, the potential for suicidal ideation and the effects of prolonged AED use on bone density (including potential impact on bones post-menopause).

We believe there is a duty to ensure patients and doctors are aware of the long-term risks. We believe these risks, the available evidence, and the number of AEDs involved are sufficient to warrant a guideline recommendation discussing and reviewing side-effects.

We do not understand why some side-effect profiles, such as specific issues for expectant mothers, can be mentioned within the guideline, yet bone health is not.

We ask the GDG to look again at whether a recommendation along these lines is appropriate, given that this issue falls within the remit of the review and the review recommends many of the potentially risky AEDs.

In the August 2010 consultation, we asked for levetiracetam to be considered as a first line treatment for generalised epilepsies (Stakeholder comments response, p106, 30.1.7). The GDG rejected this request, on the grounds that there is no available evidence for levetiracetam as a monotherapy, and it is not currently licensed for this indication.

While levetiracetam is appropriately listed for those seizure types where it is licensed. This is monotherapy and adjunctive treatment of partial seizures (with or without secondary generalisation), and as adjunctive treatment of myoclonic and primary generalised tonic clonic seizures (British National Formulary 60, September 2010, p285).

However we know levetiracetam is also widely prescribed, off-licence, as a first-line treatment of generalised seizures in adults and children. This is in part because of its low probability for interactions and it’s mechanism of action allowing easy addition to existing drug treatment.

While it may be wise for the drug manufacturers to apply for a licence for this indication, this will not improve the drug’s status now and could mean impractical advice is issued on best treatments until this guideline’s next review.

However, we believe a compromise on this issue
can be reached and we again ask that 
levetiracetam be included as a possible first-line 
treatment for generalised seizures in adults and 
children, on the basis of lower-grade evidence 
and clinical opinion.

A similar exception for non-licenced use has been 
created for the use of oxcarbazepine for 
generalised-tonic clonic seizures. While 
oxcarbazepine is not-licensed for this use, it is 
included in the guidelines, with the caveat that at 
the time of publication, licensing has not been 
granted. Similarly at various other points, 
clobazam, gabapentin, lamotrigine, zonisamide, 
eslicarbazepine acetate, pregabalin, topiramate 
and levetiracetam itself are recommended for 
certain seizures with warning that the drug is not 
licensed for this use.

Epilepsy Action does not oppose any of these 
recommendations, and we believe a similar, 
satisfactory position can be agreed for the future 
use of levetiracetam for generalised seizures. We 
want the widest possible range of treatment 
options at the disposal of the epilepsy specialist, 
for the benefit of people with the condition.

With regards to the recommendations for the 
treatment of infantile spasms, we would like to 
see a repeat of the safety warning specific to 
vigabatrin, which is stated in clause 85 (page 58).

‘Carefully consider the risk–benefit ratio 
when using vigabatrin because of the risk 
of an irreversible effect on visual fields.’

We believe the same grounds exist for the 
inclusion of a warning in infantile spasms, as for 
the recommendation of possible adjunctive use 
for focal seizures. We see no reason why this 
safety warning should not also be included here.

We believe the warning that higher doses of 
sodium valproate bring greater risks than lower 
doses, should be extended to include the similar 
higher risks from polytherapy. We propose the 
wording,

“Specifically discuss the risk of continued 
use of sodium valproate to the unborn 
child, being aware that higher doses of 
sodium valproate (>800 mg/day) and 
polytherapy treatments are associated 
with a greater risk than with lower doses (< 
800 mg/day)”. 
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| 9 | Full | 66 | 35 | We request a further change regarding a new clause concerning treatments for women. Currently, the clause reads, 

> ‘Aim for seizure freedom before conception and during pregnancy (particularly for women and girls with generalized tonic-clonic seizures) but consider the risk of adverse effects of AEDs and use the lowest effective dose of each AED’

We would like the direction ‘avoiding polytherapy where possible’ to follow. This is in-line with the Guideline’s advice on treatment by a single AED where possible. (Clause 50, lines 35-39 on page 55). Monotherapy should be desired in all patients taking anti-epileptic drugs. |
| 10 | Full | 73 & 74 | We would like to remind the GDG that a page is missing from the Full Guideline, to accompany the care pathways on pages 73 and 74. This page includes ‘Box A’. We know the GDG are aware of this error. |
| 11 | Full | 519 | In the previous consultation, The Royal College of General Practitioners suggest that the use of ‘tertiary epilepsy specialist should be avoided as it is not defined, with its meaning unclear (Stakeholder comments response, p170, 19.0.3). In response, the GDG state that the glossary has been updated accordingly. However upon examination, we do not believe the term ‘tertiary epilepsy specialist’ has been added to the glossary of the Full Guideline. We would welcome the addition of this definition to the next version of the Full Guideline, to fulfil the action from the first consultation. |

Please add extra rows as needed

**Please email this form to:** epilepsyupdate@nice.org.uk

**Closing date:** 5pm on 26.01.11

**PLEASE NOTE:** The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion or the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.